A DISCOURSE ANALYSIS OF CLINICAL PSYCHOLOGISTS' TALK ABOUT COLLABORATION IN THE CONTEXT OF FORMULATION IN CBT FOR PSYCHOSIS

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ABSTRACT

BACKGROUND:

There is a dominant discourse within the literature that collaboration is the ideal way of working when formulating in CBT and particularly with clients experiencing psychosis. Despite formulation and collaboration being considered key principles for this widely evidence-based approach, the literature deconstructing these concepts or explicating the way these add value to CBT for psychosis is insufficient. The literature does not acknowledge complexities, challenges or inconsistencies regarding this dominant discourse. This may be due to methodological challenges of investigating such variable and abstract constructs. However discourse analysis is a productive way of investigating inconsistent and complex constructs. Foucauldian Discourse Analysis was utilised within this study to investigate how clinical psychologists talk about and construct collaboration within this context, discourses drawn upon, tensions apparent, and ways of managing these.

DESIGN:

Semi-structured interviews were conducted with 12 clinical psychologists working across 3 NHS trusts in England. All participants self-reported working with clients experiencing psychosis and developing cognitive-behavioural formulations with these clients. A local collaborator within each trust provided names and contact details of clinical psychologists working with this client group, all of whom were sent participant invitation letters. Interviews were transcribed verbatim using a light version of Jeffersonian transcription, according to the level of analysis.

ANALYSIS:

Foucauldian Discourse Analysis was used to analyse the data and the guidelines of Willig (2008) were heavily drawn upon. This involved investigating how collaboration was constructed in accounts and inconsistencies or variations in this; discourses drawn upon; close examination of the discursive context and

the action orientation of talk within the interview; subject positions adopted; and the relationship between discourse, practice and subjectivity.

RESULTS:

Collaboration in the context of formulation in CBT for psychosis was constructed in diverse and inconsistent ways by participants. Collaboration was often initially presented as a straightforward process whilst accounts quickly moved on to construct this as complex and ambiguous. Clinical psychologists adopted multiple and seemingly conflicting positions within their talk such as 'collaborator' but also 'expert' and 'protector'. Tensions were apparent between conflicting discourses drawn upon such as 'collaboration as the ideal' but also 'openness and transparency as dangerous' and the 'importance of a shared understanding' alongside 'accepting multiple perspectives'.

CONCLUSION:

Current understandings of collaboration presented in the literature are inadequate and a more nuanced understanding of the complexities, tensions and variations of collaboration in CBT for psychosis, as presented by participants is called for. The research highlights that collaboration may be more usefully constructed as being made up of a range of approaches rather than as a singular way of working. It may be useful to consider an approach similar to the 'matching hypothesis' seen in health and social psychology literature when determining type of collaboration and therapeutic alliance suitable for the individual.

STATEMENT OF CONTRIBUTION

The first author and chief investigator, Laura Stone, was primarily responsible for the design of the study, applying for ethical approval, organising recruitment, reviewing the literature, conducting interviews and analysing transcriptions for the study. The second author, Dr Anna Tickle offered supervision and support throughout the project including regarding the initial design of the project, ethics applications, recruitment and preparation of interview schedules, as well as having input into the analysis and write up of the project. Dr Mike Rennoldson offered regular supervision and support for facilitating my learning of discourse analysis, analysis of transcripts, conclusions drawn and the write up of the project.

Local collaborators from each participating NHS trust: Dr Justine Hardy, Dr Louise Braham and again Dr Mike Rennoldson provided names and contact details of potential participants for the study to facilitate recruitment.

SYSTEMATIC LITERATURE REVIEW

‘JUMPING TO CONCLUSIONS’ IN PERSECUTORY DELUSIONS: A SYSTEMATIC REVIEW OF THE EMPIRICAL LITERATURE*

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* This review has been prepared for submission to the British Journal of Clinical Psychology.

ABSTRACT

Objectives

This review aimed to determine whether the 'jumping to conclusions' (JTC) data gathering bias previously identified in those with delusions is present in people with the persecutory subtype.

Method

A systematic review of the literature was conducted through searching databases and reference lists. Five databases were searched: AMED, EMBASE, MEDLINE, PsycArticles and PsycInfo. Search terms used were: paranoi*, persecutory, delusion, ideation, jump* to conclusion*, JTC, data gathering, probabilistic, reasoning. Identified studies were subject to quality appraisal and information including participants, assessment of JTC, confounding variables, and study findings, were extracted from the data.

Results

Seven studies were selected for review in line with eligibility criteria. The studies all assessed JTC in those with persecutory delusions compared to controls. The majority of studies utilised probability reasoning tasks and measured a number of pieces of information requested prior to making a decision. The findings overall support the presence of a data gathering bias in those with current, but not remitted, persecutory delusions compared to psychiatric and healthy controls. However, there was some variability in the findings.

Conclusions

The findings support previous evidence regarding the association between JTC and delusions. Based on the studies reviewed this conclusion can only be drawn for individuals with current, rather than remitted persecutory delusions. Furthermore, the review found this bias to be transdiagnostic. The results add further weight to the evidence base for the role of cognitive biases in persecutory delusions.

PRACTITIONER POINTS

Positive Clinical Implications

- The role of cognitive biases within persecutory delusions is supported by the findings.
- The review provides further evidence to support the utility of a cognitive-behavioural framework for understanding persecutory delusions.
- The findings support the utility of assessing cognitive biases in attribution and decision making for individuals experiencing persecutory delusions. This would focus formulations and interventions on key processes involved in the development and maintenance of delusions.

Limitations of the review

- The review cannot explain why the bias is present in some individuals with persecutory delusions and not others, or factors differentiating these groups.
- There is not enough evidence to conclude that this bias cannot be better accounted for by affects of antipsychotic medication or the presence of other delusion subtypes.

BACKGROUND

Persecutory Delusions

Definition

Delusions as described here are situated within a Western medicalised perspective and it is acknowledged that such beliefs may be regarded differently within other cultural contexts. Delusions are described in the DSM-IV (American Psychiatric Association [APA], 1994) as 'erroneous beliefs that usually involve a misinterpretation of perceptions or experiences' (pp.275). Persecutory delusions are a subtype, defined by content (Freeman & Garety, 2004). Freeman and Garety (2004) reviewed definitions of persecutory delusions and found several discrepant operational definitions available (e.g. APA, 1994; World Health Organisation [WHO], 1992). They developed a definition they suggest is less ambiguous and more detailed, in which two criteria must be met:

a) The individual believes that harm is occurring, or is going to occur, to him or her.
b) The individual believes that the persecutor has the intention to cause harm.

It has been suggested persecutory delusions are the most common subtype (APA, 1994). Persecutory delusions can be present in a number of psychiatric (e.g. Johnson, Horworth & Weissman, 1991) or neurological (e.g. Flint, 1991) conditions, and can be associated with alcohol use or other pharmacological agents (e.g. Cutting, 1987). They are a common experience for those with psychosis, occurring in 50% of cases (Sartorius *et al*., 1986) and 56% of individuals with a diagnosis of schizophrenia (Cutting, 1997, cited in Freeman & Garety, 2004). These findings support the utility of investigating specific symptoms, rather than diagnostic categories.

Paranoia and persecutory delusions

The term paranoia or paranoid delusions are often used interchangeably with persecutory delusions (e.g. Bentall *et al*., 2009; Corcoran *et al*., 2007)

suggesting shared characteristics of the two concepts. Evidence suggests paranoia can be experienced in non-clinical populations and exists on a continuum. Those in the general population may experience paranoia as increased suspiciousness or beliefs about neighbours trying to get at them, while at the other end of the continuum those with persecutory delusions may believe the government are plotting to kill them (Freeman, 2007; Freeman, Pugh, Vorontsova, Antley, & Slater, 2010). Additionally, it has been shown that low level symptom occurrence increases risk of clinical disorder (e.g. Dominguez, Wichers, Lieb, Wittchen & Van os, 2011; Van os, Hanssen, Bijl & Ravelli, 2000).

It is important to note the difference between paranoia and persecutory delusions. Ellet, Lopes and Chadwick (2003) discuss characteristics of paranoia as including beliefs about conspiracy, others trying to influence behaviour, or general suspicion and mistrust. The literature suggests therefore that paranoia describes a wider concept, which could include persecutory delusions, but also milder suspicions.

Consequences

Persecutory delusions are claimed to be the most distressing subtype (Freeman & Garety, 2004), associated with the highest levels of negative affect (Appelbaum, Robbins & Roth, 1999). Evidence suggests that within individuals with Schizophrenia, persecutory delusions are more associated with violence and anger than other subtypes (Cheung, Schweitzer, Crowley, & Tuckwell, 1997). Additionally, persecutory delusions as well as auditory hallucinations have been found to be the strongest predictor of admission to hospital for individuals with non-affective functional psychosis (Castle, Phelan, Wessely, & Murray, 1994). These findings emphasise the importance of understanding this experience and developing 'interventions that accurately target key processes' (Freeman & Garety, 2004, p.6).

Cognitive model of persecutory delusions

Cognitive model

Recently there has been development in understanding persecutory delusions as a phenomenon of interest in its own right rather than merely a symptom of a wider disorder (Freeman, 2007). Studies have begun to investigate possible cognitive mechanisms in the development and maintenance of delusions, including reasoning and attributional biases and theory of mind difficulties (Garety & Freeman, 1999).

Treatment

The evidence base for using Cognitive Behaviour Therapy (CBT) for psychosis has grown over the last decade (e.g. Tarrier, 2005; Tarrier & Wykes 2004). National Institute of Clinical Excellence (NICE; 2009) guidelines recommend CBT for Schizophrenia. Freeman and Garety (2004) point out that as different mechanisms may be involved in the development of different symptoms, interventions may have differential effects. More recently a Cochrane review (Jones, Hacker, Cormac, Meaden & Irving, 2012) found CBT to not be any more effective than other psychosocial interventions for individuals with Schizophrenia. These mixed findings support the need for a 'top down' approach to investigate whether the constructs in cognitive theory are substantiated by evidence, as well as the 'bottom-up' approach to investigate whether CBT leads to improved outcomes (Bieling & Kuyken, 2003).

'Jumping to conclusions' and delusions

Measures of JTC

Presence of the 'Jumping to conclusions' (JTC) bias in delusions was first assessed by Huq, Garety and Hemsley (1988) using a probabilistic reasoning task. They found those with diagnoses of Schizophrenia and current delusional symptoms made decisions based on less information than non-delusional psychiatric, and 'healthy', controls, and were more certain about their decisions.

It has been suggested that a Bayesian model of probabilistic inference provides a useful approach for assessing reasoning in people with delusions as it provides a normative framework (Garety & Freeman, 1999) for hypothesis evaluation and prescribes how hypotheses should be evaluated (Fischhoff &

Beyth-Marom, 1983). Hypotheses-evaluation behaviour can then be characterised in terms of how much it departs from, or is consistent with, the model (Fischhoff & Beyth-Marom, 1983).

Probabilistic reasoning experiments are commonly employed in researching JTC bias. Typical experiments of this type (e.g. Phillips & Edwards, 1966) involve showing bags containing red and blue poker chips. Participants are informed that the bags are either predominantly red or blue and that there are ratios of (for example) 70% red to 30% blue chips or vice versa. The chips are then drawn one at a time (participants are told this is random) and then replaced. Experiments may measure number of draws to decision (DTD), or estimates after each chip is drawn, of the probability of these being drawn from one container in a fixed number of trials (Garety & Freeman, 1999). It is important to note that the JTC bias may not represent a deficit; Phillips and Edwards (1966) found participants (undergraduate men) to be conservative with their estimates. It has since been suggested by Maher (1992, cited in Garety & Freeman, 1999) that the JTC bias may actually represent better Bayesian reasoning than over-cautious controls. It is acknowledged that there may be limitations of relating performance in such tasks to the development of delusional beliefs, but such experiments have been used to establish whether there are fundamental differences in cognitive processing between individuals with and without persecutory delusions. An understanding of whether such differences exist is vital to informing assessment, formulation and interventions.

JTC and delusions

Garety and Freeman (1999) reviewed the literature regarding the role of cognitive processes in delusion formation and maintenance, including JTC. Eight studies, using modifications of the basic probabilistic reasoning paradigm with ratios 85:15 were included. Seven studies supported the JTC tendency in those with delusions. However, this was only demonstrated in tasks assessing DTD, rather than fixed trials where probability estimates were given. This indicates although those with delusions often make decisions based on less information, they are not necessarily more certain in their choice. The review

concluded this bias was not a function of memory deficit or impulsiveness and that it may be present in those with delusions irrespective of diagnosis. Additionally, they concluded JTC is more likely across groups for emotionally salient stimuli, but this may be further exaggerated in those with delusions. No evidence of an association between gender and JTC was found, and findings regarding the contribution of IQ to performance was mixed. The review suggested that when JTC is categorised as selecting only one piece of information prior to decision, it is present in a significant proportion of those with delusions (between 40 and 70%). Contrary to Maher's comment (1992, as cited in Freeman & Garety, 2004) findings suggested the data gathering bias can lead to acceptance of incorrect hypothesis.

JTC and persecutory delusions

The literature suggests that sub-types of delusions have a degree of independence (Vazquez-Barquero, Iastra, Nunez, Castanedo & Dunn, 1996), indicating there may be non-shared causes. It is therefore important to determine whether cognitive processes associated with delusions in general are also associated with specific subtypes. Studies have begun to look at the role of JTC in persecutory delusions. Freeman (2007) conducted a review of the empirical literature on psychological processes associated with persecutory delusions, including anomalous experiences, affective processes and reasoning (JTC, theory of mind and attributional biases).

Freeman (2007) reviewed 10 studies in which participants with delusions were compared to those without on tasks of probability reasoning using measures of DTD. This review did not appear to be conducted systematically but offers useful information about JTC in individuals with delusions. However, seven studies provided information about the proportion of participants with persecutory subtype but did not separate these groups within experiments. Individuals with specifically persecutory delusions were the focus of only one study reviewed. This study found JTC was present in 50% of those with persecutory delusions, compared to 10% of controls. The review drew the tentative conclusion that JTC is often present in those with persecutory

delusions but it is difficult to generalise these findings based on one study with a total sample size of 58. Additionally the study focused on persecutory delusions was an unpublished thesis, therefore not necessarily ensuring high quality.

Importance of current review

As discussed, persecutory delusions are a common experience for individuals with psychosis and are associated with more distress, anger, violence and hospital admission than other subtypes. It is therefore important to further understand psychological processes involved in the development and maintenance of persecutory delusions. It has been concluded that a JTC bias is present in many of those with delusions and studies have shown the bias is present for some individuals with persecutory delusions. Studies to date have not previously been systematically reviewed so that findings can be synthesised and broader conclusions drawn about the role of this bias. If specific processes can be identified, interventions can be developed to target such processes e.g. reasoning training.

The current study aims to systematically review the literature to determine whether the JTC bias is present in those with persecutory delusions compared to those without.

METHODOLOGY

Five databases were systematically searched on the 21st July 2012 through Ovid SP advanced search system. References from selected studies were later trawled to identify further potential studies. Titles, abstracts and where necessary full texts were obtained, if eligible the paper was then selected for review.

Eligibility criteria

Inclusion:

- Human participants currently experiencing persecutory delusions, as well as a control group of those who are not.

- Assessment of persecutory delusions should be comprehensive and meet the definition given by Freeman and Garety (2004): the individual believes that harm is occurring, or is going to occur to him/her, and the individual believes the persecutor has the intention to cause harm.
- Objective assessment of how much information participants request prior to making a decision e.g. using a probabilistic reasoning task.
- Information regarding participants numbers of 'draws to decision' (DTD) or whether participants 'jump to conclusions' (usually measured by selecting 2 or less pieces of information before decision) should be available.
- Quantitative design.
- Statistical analysis of results should assess whether a significant difference exists between those with persecutory delusions and those without.
- Published in a peer reviewed journal, to control for quality.

Exclusion:

- Studies of participants with 'paranoid ideation' but not assessed as experiencing persecutory delusions (due differences between paranoia and persecutory delusions).
- Studies which only include participants with persecutory delusions as part of a wider group (e.g. Schizophrenia) but for whom separate data regarding data gathering style is not available.
- Studies only published or accessible in languages other than English.
- Studies published prior to 1980 were excluded, to reduce number of irrelevant studies assessed, as data gathering style in deluded participants was first studied in 1988 (Huq, Garety & Hemsley).

Literature search

Five databases: AMED, EMBASE, MEDLINE, PsycArticles and PsycInfo were chosen for their access to large numbers of journals across broad date ranges, of relevance to the review question and topic area.

Search strategy

Ovid SP was used to develop the search, using terms relevant to the question and eligibility criteria. The search was set up using the PsycInfo database and then conducted simultaneously through all five databases. Key words and phrases were selected to expand on the two key concepts of the study: persecutory delusions and jumping to conclusions. Search terms were then combined, aiming to retrieve only studies relating to both these concepts. The full search strategy with Boolean operators and number of results retrieved are presented in Table 1**.**

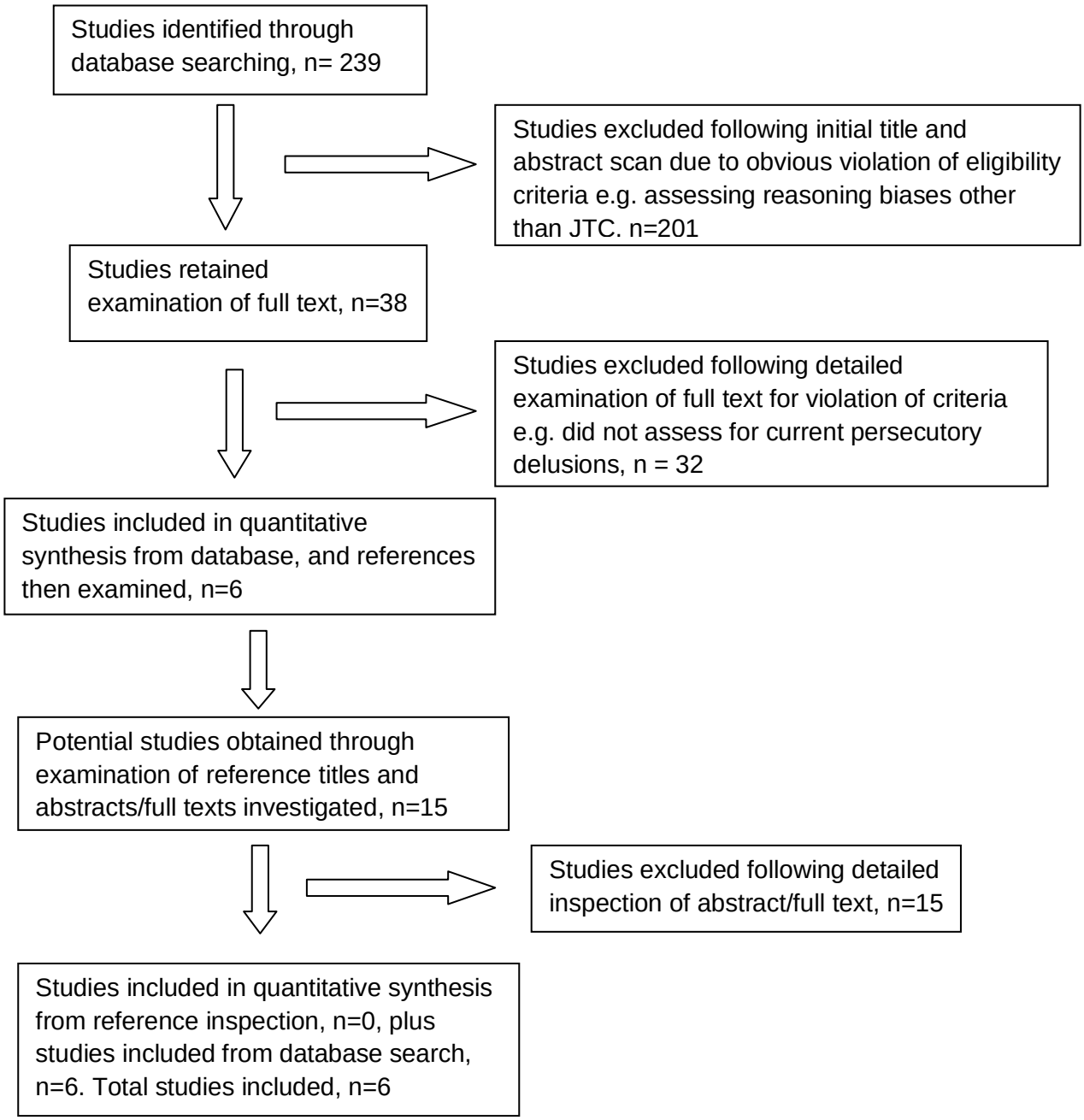
Table 1. Search strategy entered into Ovid SP database search

#	**Searches**	**Results**
1	paranoi*	39390
2	persecut*	6902
3	delusion or ideation	43240
4	2 and 3	1773
5	1 or 4	40468
6	(jump* to conclusion*) or JTC	1137
7	(data gathering)	3532
8	Probabilistic and reasoning	1845
9	Reasoning and bias	8255
10	6 or 7 or 8 or 9	13730
11	5 and 10	315
12	Limit 11 to English language [limit not valid in Journals@Ovid; records were retained]	310
13	Limit 12 to human [limit not valid in AMED, Journal@Ovid; records were retained]	303
14	Limit 13 to humans [limit not valid in AMED, PsychInfo, Journals@Ovid; records were retained	303
15	Remove duplicates from 14	247
16	Limit to yr = ”1980 – current”	239

Selection

The database search retrieved 239 studies. Following a screening of all 239 titles and abstracts, 38 full texts were obtained to consider in further detail. Of these 38 papers, 6 met all eligibility criteria and were selected for review. References for all selected studies were trawled; no additional studies were selected through this process. This selection process is presented in the flow diagram in Figure A.

Figure A. Flow diagram to represent selection process



Quality appraisal

The Critical Appraisal Skills Programme (CASP, 2006) provides checklists to aid the appraisal of research study quality, including a specific checklist for case control studies. This checklist was modified for the review, to cover aspects of quality assurance specific to the nature of the studies being reviewed. The ‘yes’ and ‘no’ answers in the checklist were deemed restrictive, so instead a number of stars were assigned from one to five, with five symbolising the highest level of quality and one the poorest. The modified checklist sets out 10 questions broadly addressing three issues: are the results of the study valid; what are the results, and will the results help locally. The modified checklist is available from the first author. Table 2 shows results of the quality appraisal of the studies selected for review.

Data extraction

General characteristics and key findings of selected studies were extracted and are demonstrated in Table 3**.**

Table 2. Quality appraisal of selected studies

		Quality rating ***** = highest quality						
Study	**1.**	**2.**	**3.**	**4.**	**5.**	**6.**	**7.**	**8.**
1.Corcoran et al. (2008)	Y	****	****	*****	**	****	*****	**24**
2.Fraser, Morrison & Wells (2006)	N	***	***	*****	**	**	***	**18**
3.Freeman et al (2010)	Y	***	****	*****	****	**	***	**21**
4.Merrin, Kinderman & Bentall (2007)	Y	**	*****	****	*****	*****	***	**24**
5.Moore et al. (2006)	N	****	****	****	***	***	****	**22**
6.Startup, Freeman & Garety (2008)	Y	****	****	***	*****	****	*****	**25**

Table 3. Key characteristics and findings of selected studies

Study	Participants	Recruitment	Assessment of Persecutory Delusions (PD)	Psychiatric diagnoses of PD group	Assessment of JTC	Measurements of JTC	Key findings
1.Corcoran et al. (2008)	n=39 current PD (mean age: 34) n=29 remitted PD (mean age: 35) n=20 current PD, depressed (mean age: 36) n=27 non-psychotic depressed (mean age: 48) n=33 healthy adults (mean age: 39) Age range: not specified	Psychiatric: inpatient and outpatient Non-clinical: through advertisement	Evidence of PD[1] in case notes and endorsement of items in SCAN[2] interview and PDI[3]	Schizophrenia, Schizoaffective disorder and delusional disorder.	1. Classic beads task (60:40) 2. Social version: positive and negative comments about a person (60:40)	1. DTD[4]	Those with PD took less DTD than controls on both neutral and social probabilistic reasoning tasks. Findings suggest JTC is specific to current PD, not remitted and is transdiagnostic. Rregression analysis showed significant predictor variables of age and IQ to DTD, PD also remained an independent predictor.
2.Fraser, Morrison & Wells (2006)	n=15 current PD (mean age: 38) n=15 Panic Disorder (mean age: 41) n=15 non-patient controls (mean age: 40) Age range: 20-62	Psychiatric: does not state in- or out-patient Non-clinical: advertisement and informal contacts	DSM-IV diagnosis of Schizophrenia spectrum disorder or delusional disorder, and evidence of PD in case notes and interview	Schizophrenic spectrum disorder or delusional disorder (DSM-IV)	1. Neutral probabilistic reasoning task: male and female children's names (60:40) 2. Self-referent: positive and negative personality traits 3. Panic related:	1. DTD	No significant effect of group; does not support hasty decision making in those with PD compared to those with panic disorder or healthy controls. However, group means for all 4 reasoning tasks were lower in the PD group, suggesting statistical trend.

[1] PD (persecutory delusions)
[2] SCAN (Schedules for Clinical Assessment in Neuropsychiatry, WHO, 1992)
[3] PDI (Peters Delusion Inventory, Peters et al., 1999)
[4] DTD (draws to decision)

						positive and negative panic related words (60:40)		
3.Freeman et al (2010)	n=30 current PD (mean age: 44) n=30 low paranoia non-clinical (mean age: 44) n=30 high paranoia non-clinical (mean age: 36) Age range: required to be 18-65, actual range not specified	Psychiatric: adult psychiatric service (does not state in- or out-patient) Non-clinical: advertised through leaflets	Diagnosis of Schizophrenia, Schizoaffective disorder or delusional disorder, current PD using Freeman and Garety's definition, assessed by G-PTS[1] and PSE[2]	Schizophrenia, Schizoaffective disorder, delusional disorder	1.	Classic beads task (60:40)	1. DTD	Significant group effect on beads task (PD group made a decision based on less information than control).
4.Merrin, Kinderman & Bentall (2007)	n=24 current PD (mean age: 38) n=24 depressed psychiatric (mean age: 45) n=24 healthy controls (mean age: 38) Age range: 17-63	Psychiatric: in- and out-patient Non-clinical: recruited through informal contacts	PD defined using Freeman & Garety's (2000) criteria, assessed through medical records, nursing reports, self-reports, presentation during KGV[3] interview	Schizophrenia, Schizoaffective disorder, bipolar	1.	20 questions reasoning task: presented with negative event, could ask up to 20 questions (yes or no answers given) to decide about the cause of the event (from 3 pre-prepared choices)	1. DTD	Significant main effect of group on mean number of questions asked: PD group asked less questions than depressed and healthy controls. Although both depressed mood and estimated IQ associated with DTD, regression analyses showed PD status to independently (additionally to depression and IQ) predict JTC.

[1] G-PTS (Green, Freeman & Kuipers et al., 2008)
[2] PSE (Present State Examination, WHO, 1992)
[3] KGV (Krawieca, Goldberg & Vaughn, 1977)

5.Moore et al. (2006)	N=29 current PD and late-onset SLP[1] (mean age: 77) N=30 major depressive disorder (mean age: 77) N=30 healthy control (mean age: 76) Age range: not specified, required to be over 60	Psychiatric: in- and out-patient Non-clinical: recruited through 'lunch club' for older adults	Diagnosis of very-late-onset SLP, endorsement of persecutory items on PDI and evidence of PD in case notes	Very-late-onset SLP	1. Classic beads task (60:40)	1. DTD 2. 'extreme responders' categorised and compared	No significant differences between those with PD (and SLP), depressed participants and healthy controls on number of DTD or numbers of 'extreme responders.
6.Startup, Freemna & Garety (2008)	N=28 current PD (mean age: 35) N=30 healthy control (mean age: 37) Age range: not specified, required to be 18-65.	Psychiatric: all inpatients Non-clinical: advertisement	PD defined by criteria set out by Freeman & Garety, assessed medical notes, used paranoia questions from PSE questionnaire and PSYRATS[2]	Schizophrenia, Schizoaffective disorder, delusional disorder, bipolar, personality disorder	1. Classic beads task (60:40)	1. DTD 2. JTC determined if decision made after 2 or less draws	Significantly more participants in PD group showed JTC style, analysed using chi squared (2 or less draws defined JTC). When DTD investigated across groups, no significant difference found, only statistical trend.

[1] SLP (Schizophrenia like psychosis)
[2] PSYRATS (Haddock et al., (1999)

RESULTS

Six studies were included for review: four (Corcoran *et al*., 2008; Freeman *et al*., 2010; Merrin, Kinderman, & Bentall, 2007; Startup, Freeman, & Garety, 2008) supported the presence of a data gathering bias in those with persecutory delusions (PD) compared to psychiatric and healthy controls. That is, those with PD request less information before making a decision. Two (Moore *et al*., 2006; Fraser, Morrison, & Wells, 2006) of the studies showed the mean number of DTD were lower in the PD group, however this did not reach statistical significance. These findings are discussed below in more detail, with consideration to potential sources of bias examined by the quality assessment tool.

Assessment of JTC

Neutral (e.g. classic beads task) and socially meaningful probabilistic reasoning tasks were used to assess JTC in the studies. The two studies which employed an additional socially meaningful task used the framework set out by Dudley, John, Young and Over (1997) using the same ratios as for the neutral tasks. This involved positive and negative comments about a person being shown to the participant, who then had to decide whether the comments came from a predominantly positive or negative survey. The results indicate those with PD may request less information before making a decision, regardless of stimuli type used. One study employing both neutral and meaningful tasks (Corcoran *et al.,* 2008) found significant differences across groups in the neutral task. Descriptive statistics indicated a statistical trend supporting the presence of this bias in the meaningful task but the difference between groups fell just short of statistical significance when IQ was controlled for. One other study used both neutral and meaningful tasks (Fraser *et al*., 2006) and investigated effect of stimuli, finding less information was requested with emotional stimuli rather than neutral. Stimuli type affected reasoning process similarly across groups. There is not enough evidence therefore to suggest type of stimuli affects whether or not a difference in JTC is found between PD and non PD groups.

One study also employed measures of certainty (Merrin *et al*., 2007) and did not find an association between PD and confidence in decision, suggesting those with PD are not more confident despite making a decision earlier. Only two studies compared numbers of 'extreme responders' across groups as well as DTD (Moore *et al*., 2006; Startup *et al*., 2008). Moore *et al*. (2006) did not find significant differences across groups for either measure. Startup *et al*. (2008) found that despite DTD not reaching significance, numbers of those who made a decision after two or less draws significantly differed across groups. This indicates the bias is only present in a proportion of the PD group, suggesting a larger proportion of those with PD have an extreme JTC style, rather than a small difference being observable in the majority.

Participants

Half of the studies (Fraser *et al*., 2006; Merrin *et al*., 2007; Moore *et al*., 2006) employed three groups: those with PD, psychiatric controls, and non-clinical controls. Corcoran *et al*., 2008 employed a wider range of groups, however for the purpose of analysis three contrasts were investigated: 'current PD vs no current PD'; 'schizophrenia spectrum PD vs depressed PD'; and 'remitted PD vs depressed no PD vs healthy control'. These findings suggest there is a difference in data gathering style between those with current and remitted PD, indicating this bias is associated to state rather than trait.

Freeman *et al*. (2010) investigated differences between those with PD and general population groups with high and low paranoid ideation. The findings suggested the JTC bias does not have a 'dose response' relationship to paranoia: those with clinical PD took less DTD, however no difference was observed between those with high and low paranoid ideation in the general public. None of the studies included groups of participants with other subtypes of delusions. In all studies, measures were put in place to screen control groups for the presence of delusions.

Participants in the PD groups had a range of diagnoses, suggesting the observed bias is associated with PD experience rather than a specific diagnosis. The only exception to this was seen in Moore *et al.*'s (2006) study.

The PD group were all diagnosed with late-onset Schizophrenia-like-psychosis (SLP), over age 60. There was no significant difference in data gathering style between groups in this study, possibly suggesting a difference in reasoning style in older adults.

Half of the studies (Startup *et al*., 2008; Merrin *et al*., 2007; Freeman *et al*., 2006) matched participants for age. Corcoran *et al*., (2008) did not match participants on age, however they did investigate whether this variable could have confounded the results. They found age predicted performance; younger participants requested less DTD. Moore *et al*., (2006) did not find any significant differences between groups on age and Fraser *et al.,* (2006) did not investigate age as a confounding variable at all, suggesting a potential limitation of this study.

Half of the studies (Freeman *et al*., 2010; Merrin *et al*., 2007; Startup *et al*., 2008) matched participants for gender. One study, Corcoran *et al*. (2008) investigated potential confounding effects of gender; this was not a predictor of DTD.

All studies reported assessing persecutory delusions using a combination of psychiatric diagnosis, staff reports, case notes and self-reports. Total sample sizes across the studies were varied, ranging between 45 (Fraser *et al*., 2006) and 115 (Corcoran *et al.*, 2008). The total number of participants in all studies reviewed was 469, with the total number of participants with PD 185. The study with the smallest sample based this number on effect sizes found in previous studies, suggesting it was not the sample size which rendered the findings of this study non-significant. The large sample sizes among the studies are a strength of this review and suggests the findings can be generalised.

Confounding and interacting variables

All studies employed measures of cognitive performance to estimate IQ. Three studies (Startup *et al*., 2008; Moore *et al*., 2006; Fraser *et al.*, 2006) found no association between DTD and IQ. Merrin *et al*. (2007) conversely found IQ significantly associated with DTD; however the multiple regression analysis showed PD was also an independent predictor of JTC. Corcoran *et al.* (2008)

found that for the classic beads task, IQ did not significantly predict performance, however, on the social version this did. Freeman *et al*., (2010) did not investigate this relationship. Results suggest IQ is not usually associated with DTD and that IQ and JTC are independent from one another but there may be some overlap.

Only one study (Corcoran *et al*., 2008) investigated the effect of antipsychotic medication (chlorpromazine equivalent) on JTC performance, finding no significant correlation between the two. This suggests antipsychotic medication is not associated with data gathering style but this cannot be concluded based on one study.

Half of the studies provided a memory aid within the task; two (Moore *et al*., 2006; Startup *et al.*, 2008) displayed the beads drawn (rather than placing back in the jar) and Merrin *et al.,* (2007) provided a summary of previous questions and answers every five minutes or when requested. None of the studies actually measured memory ability or investigated the relationship with JTC. Two of the studies which provided memory aids (Startup *et al*., 2008; Merrin *et al*., 2007) still found significant differences on performance between groups, suggesting JTC cannot be explained simply as a memory deficit.

Measures of mood (anxiety and depression) were conducted by four studies (Merrin *et al.,* 2007; Fraser *et al.,* 2006; Freeman *et al*., 2010; Moore *et al*., 2006). Merrin *et al.*, (2007) found depression (measured by BDI[1]) predicted DTD independently to PD status. Additionally, Fraser *et al*., (2006) found this association neared significance (p=0.09), Two studies (Merrin *et al*., 2007; Moore *et al.,* 2006) included controls with major depression, finding those with PD had lower mean DTD than depressed controls. The findings warrant further investigation of the relationship between depressed mood and JTC in the context of PD.

Only one study considered the effect of other delusion subtypes; Startup *et al.* (2008) found a difference in numbers of those who experienced additional delusions of reference between groups of those who JTC (extreme responders)

[1] Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961)

and those who do not. More individuals in the non-JTC group also had delusions of reference. A tentative conclusion can be drawn from this; delusions of reference are not associated with JTC but this cannot be generalised from one study.

DISCUSSION

The findings of the review suggest individuals with persecutory delusions draw less information than controls prior to making a decision. The findings suggest this bias is transdiagnostic and provides evidence to further support the cognitive model of persecutory delusions.

Based on the participants included in the studies reviewed, this can only be said for individuals with current, rather than remitted persecutory delusions. This supports previous evidence regarding the association between JTC and delusions (e.g. Garety & Freeman, 1999) and shows the bias is frequently present in the persecutory subtype. It is plausible this bias affects 'belief formation and maintenance, enabling the rapid acceptance of implausible explanations' (Freeman, 2007, p.437). However, given Corcoran *et al.*'s (2008) findings that those with remitted PD did not show evidence of JTC, the direction of causality between JTC and PD cannot be confirmed. The findings that hasty data gathering style is not seen in those with remitted PD or those with high paranoid ideation contradicted previous findings (e.g. Colbert & Peters, 2002; Mortimer *et al*., 1996). Further investigation of JTC within individuals with remitted PD is warranted.

Findings from this review suggest a JTC bias (measured by two or less DTD) to be present in approximately 50% of individuals with persecutory delusions, compared to 10% of those without, in line with previous findings (e.g. Mortimer *et al.,* 1996). Therefore, although JTC is present in a significant proportion, it cannot be claimed that JTC plays a role in the development and maintenance of persecutory delusions for all those affected.

Findings suggest although type of stimuli used (neutral or meaningful) may affect data gathering style, this difference is seen across groups and is not

exaggerated in those with PD, contradicting previous studies (e.g. Dudley, *et al*., 1997). The results indicate IQ is not associated with data gathering style, again contradicting previous findings (e.g. Bentall *et al*., 2009). However, variability in the findings suggests overlap between these two processes. The results support that the JTC bias is not a function of memory deficit, as memory aids did not affect this difference. Furthermore, the results support previous findings (e.g. Dudley *et al*., 1997) that those with PD are not more certain about decisions, despite drawing the conclusion more hastily.

The results suggest, in line with Beck's cognitive model (1987), that depressed mood is also associated with JTC. However, this appears to be independent of the relationship with PD. Additionally, in contrast to other studies (e.g. Menon, Mizrahi & Kapur, 2008) no association between antipsychotic medication and JTC was shown within the one study that accounted for medication, suggesting the need for further investigation of this relationship. Finally, findings indicate the data gathering bias cannot be accounted for by other delusion subtypes.

Strengths and limitations

A strength of the present review is that it was conducted in a systematic and replicable manner, drawing on a broad range of databases to ensure that all possible studies relevant to answering the review question in accordance with the eligibility criteria were assessed. Both a strength and limitation is the focus on peer reviewed published and experimental studies using similar tasks. While this enables comparison between studies considered to be of good quality, it led to the exclusion of studies using other methods, which may aid understanding of the jumping to conclusions bias within persecutory delusions.

Further strengths of this review include the large total sample size across the studies. Additionally, the studies were thorough in their assessment of individuals' persecutory delusions and in screening controls for delusions. Psychiatric groups as well as non-clinical controls were used in the majority of studies, to control for differences in reasoning associated with general mental illness rather than persecutory delusions. Recruitment utilised both inpatient and outpatient settings, and for controls advertisements were used to recruit a

heterogonous sample. These factors increase the reliability, validity, and generalisability of the findings.

A limitation of the studies included is that the majority employed probability tasks using ratios 60:40, this differs from previous studies, which mainly used an 85:15 ratio (e.g. Mortimer *et al.*, 1996). It has been suggested that an 85:15 ratio creates an easy task to reduce floor effects (Garety & Freeman, 1999). However, the findings were mostly replicated, suggesting the 60:40 ratio was still able to differentiate between those with persecutory delusions and those without.

Most of the studies assessed JTC using DTD; however previous research has mainly looked at numbers of extreme responders across groups (e.g. Fear & Healey, 1997). It is important to differentiate whether the JTC bias represents a small difference in DTD across many, or a large difference for a few, for purposes of intervention development and informing practice.

Limitations noted across the studies included a general absence of investigation of potential interacting and confounding variables including other delusion subtypes, medication and mood.

Implications

The findings support that interventions to target the JTC bias in many individuals with persecutory delusions may be beneficial. Assessment of data gathering style for individuals with persecutory delusions may be useful to identify whether this bias is present, informing formulation and intervention planning. For example, individuals could be encouraged to become aware of this tendency to make hasty decisions and work towards taking more time to make decisions, considering and evaluating the available evidence. Cognitive-behavioural interventions which encourage such skills may be beneficial but would require evaluation.

Future Directions

The findings support the utility of investigating processes involved with specific symptoms rather than diagnoses. It would be useful for future research to

further investigate whether this bias is present in other subtypes of delusion, as much previous research regarding delusions and JTC included large proportions of individuals with persecutory delusions. Research has not yet looked to see whether this bias is present in other subtypes or if it is specific to persecutory delusions. It would also be beneficial to review papers investigating the role of JTC in those with subclinical paranoid ideation, so conclusions can be drawn about whether this is specific to clinical persecutory delusions or is a psychological process more widely associated with the paranoia continuum.

Additionally, further research into possible explanations of the JTC bias would be clinically beneficial. Some potential explanations have been proposed, for example, motivational difficulties, impatience or difficulties sustaining attention (Merrin *et al*., 2007). However, further study into this would be required to increase understanding and inform practice. Finally, the role of potential interacting factors such as mood, medication and general cognitive functioning in JTC would benefit from further study and clarification.

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JOURNAL PAPER

A DISCOURSE ANALYSIS OF CLINICAL PSYCHOLOGISTS' TALK ABOUT COLLABORATION IN THE CONTEXT OF FORMULATION IN CBT FOR PSYCHOSIS*

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ABSTRACT

Objectives:

Despite collaboration being regarded a key principle of CBT for psychosis particularly within the formulation process, there is a paucity of literature and research exploring and unpicking this construct or explicating its value to CBT for psychosis. The literature does not acknowledge complexities, challenges or inconsistencies regarding this dominant discourse. This study aimed to investigate ways clinical psychologists talk about and construct collaboration within formulation in CBT for psychosis.

Design:

Semi-structured interviews were conducted with 12 clinical psychologists from 3 participating NHS trusts who self-reported using cognitive-behavioural approaches when formulating with individuals with psychosis.

Methods:

Discourse analysis was utilised to investigate ways in which collaboration was constructed by participants, wider discourses drawn upon, the function of talk at local interactional level and subject positions adopted.

Results:

Collaboration was constructed in diverse ways, for example as presenting a formulation to a client and requesting feedback as well as developing the formulation with the client in session. Contrasting discourses were drawn upon such as 'collaboration as the ideal' as well as 'dangers of transparency and openness' and 'professional and ethical duties of care'.

Conclusions:

Current understandings of collaboration presented in the literature are inadequate and a more nuanced understanding of the complexities, tensions and variations of collaboration, as presented by participants is called for. Reflection and openness in supervision and training, regarding the limits of

collaboration and challenges to this approach when working with those experiencing psychosis is encouraged.

PRACTITIONER POINTS:

- Practitioners need to move away from construing collaboration as a singular approach and begin to view this as being made up of several styles of working.

- Practitioners need to carefully consider the ethics of proceeding with CBT interventions when the rationale for treatment is not explicitly agreed with the client.

- Participants frequently minimised or neglected the power inherent within their role as a CBT practitioner. Participants explicitly positioned themselves instead as equal collaborators within this relationship, whilst language used also positioned them as experts and helpers. The discourse of collaboration can at times conceal the power differences within this relationship. Clinical psychologists and other CBT practitioners need to acknowledge the subtle ways in which they hold power within CBT.

- Reflection and openness in supervision and training on the limits, types and challenges of collaboration would be useful for Clinical Psychologists and other practitioners working in this field. Consideration should be given to the difficulties in achieving collaboration within a professional to service-user relationship, and particularly with service-users experiencing psychosis who are often seen within involuntary contexts, and with whom there is the potential for much disparity between beliefs and views. It is important for these tensions to be openly acknowledged so that measures can be put in place to reduce potential violation or abuse of these power differentials.

KEYWORDS: Clinical psychologists, collaboration, formulation, CBT, psychosis, discourse analysis, constructions

Background

The term ‘psychosis’ is used to describe a range of symptoms including those associated with perception distortion such as hallucinations and delusions as well as social withdrawal, amotivation and disorganisation of speech and thought (Fowler, Garety & Kuipers, 1995). It is reported that approximately 4 out of 1,000 people have or have had an active psychotic disorder over the past year and this is often associated with significant personal distress and social disability (Kirkbride *et al*., 2012). The diagnosis most commonly associated with psychosis is ‘schizophrenia’ (Kirkbride *et al*., 2012).

Please see extended background section for further information regarding the background to this study

Cognitive behavioural therapy (CBT) is a widely used evidence-based therapy recommended by the National Institute of Clinical Excellence for people with a wide range of mental health problems including schizophrenia (NICE, 2009). Many studies and reviews suggest CBT is efficacious and effective (e.g. Dixon *et al.*, 2010; Kråkvik, Gråwe, Hagen & Stiles, 2013; Morrison *et al.,* 2012; Sivec & Montesano, 2012). A systematic review comparing CBT to other psychosocial treatments for schizophrenia showed no significant difference in outcomes (Jones, Hacker, Cormac, Meaden & Irving, 2012). Evidence indicates CBT is effective when compared to waiting list controls and treatment as usual but it cannot be concluded that this approach is more beneficial than other psychosocial interventions for those with psychosis

Conducting CBT with individuals with psychosis can pose different challenges to other client groups including difficulties with engagement, associated problems such as anxiety and depression, and consequences of stigmatising perceptions of psychosis held in society (Morrison, Renton, Dunn, Williams & Bentall, 2004). These difficulties may be compounded by antipsychotic medications affecting cognitive functioning (Bentall, 2009). It has been suggested that inducing high levels of emotional arousal can lead to episodes of acute psychosis or relapse with this client group and strongly held ‘delusional’

ideas can lead to wide gap between therapist and client view of the world (Fowler *et al.*, 1995). These factors could lead to challenges when formulating collaboratively.

Collaborative formulation is frequently stated as a key principle of CBT (e.g. Morrison *et al.,* 2004) and has been defined as "a hypothesis about a person's difficulties, which draws from psychological theory" (Johnstone & Dallos, 2006, p.4). Whilst several mental health professionals include formulation in their practice the ability to develop psychological formulations for complex cases, drawing on a broad knowledge base with critical evaluation skills is seen as central to clinical psychologists' contribution to mental-health care (Kinderman & Tai, 2007).

Formulation in CBT for Psychosis

The evidence base does not offer substantial support for claims made about formulation. Research demonstrates that cognitive case formulation in CBT for psychosis significantly impacts therapists' but not clients' ratings of alliance, does not significantly impact treatment outcomes (Chadwick, Williams & Mackenzie, 2003) and can be experienced as helpful but also saddening and overwhelming (Pain, Chadwick & Abba, 2008). These studies assume that formulation happens in a particular way i.e. explicitly shared in a developmental diagram and letter. Research has begun to look at clinicians experiences of formulation use in practice. The role of formulation has been described by clinicians as including: guiding assessment and intervention; enabling the client to tell their story; as an intervention in its own right; and as a communication tool (Picken & Cogan, 2012).

Collaboration in CBT for Psychosis

Collaboration has been defined as the therapist and client working together to identify hypotheses and develop empirical tests of a client's beliefs (Morrison *et al.,* 2004; Tee & Kazantis, 2011). Forming collaborative relationships with people experiencing psychosis has been argued to require specific skills and expertise of the clinician. Collaboration is reported to be of particular importance

with clients experiencing psychosis due to potential distrust of, or delusional beliefs towards the therapist and possible therapist difficulties empathising with unusual beliefs (Tee & Kazantis, 2011) and is claimed to contribute to building trust and rapport with this client group (Fowler *et al.*, 1995). Collaboration is promoted as the preferred way of working towards recovery, as an alternative to 'delivering care' (Lester & Gask, 2006). In practice this might not seem straightforward since contested versions of reality are central to psychosis, so a shared and collaborative formulation might be considered difficult to achieve.

Current descriptions of collaboration are not fully explicated and there is a paucity of literature and research around this concept (Overholser, 2011; Tee & Kazantis, 2011). Furthermore the literature has at times equated collaboration with the therapeutic alliance (e.g. Durham, Swan & Fisher, 2000). Whilst these two constructs clearly overlap there are important differences. For example, common definitions of a good working alliance include agreement between therapist and client on tasks and goals (Bordin, 1979). Tee and Kazantis (2011) argue that collaborative empiricism in CBT consists of more than this, for example encouraging the client to take the lead role in therapeutic activities where possible and have authorship over goal and task development.

Whilst research often utilises poorly defined constructs, outcomes seem broadly consistent in supporting the role of collaboration in CBT, particularly with individuals experiencing psychosis. There has been support from case studies for claims that collaboration facilitates engagement and treatment adherence in CBT (Merali & Lynch, 1997) and that a collaborative alliance is related to treatment outcomes (Durham, Swan & Fisher, 2000; Krupnick *et al.*, 1996). These studies equated collaboration with the therapeutic alliance and did not include individuals with psychosis however. Research indicates that collaboration, as viewed by the client may not be as important as claims suggest with other types of alliance, such as 'nurturant' and 'insight orientated' being described more frequently by clients talking about a 'good therapeutic alliance' (Bachelor, 1995).

Within CBT for psychosis, research has found that collaboration (including sharing the formulation and developing shared goals) and empathy are central

for the development of a therapeutic relationship (Evans-Jones, Peters & Barker, 2009). Client ratings of therapist 'expertness' in this study were also linked to the therapeutic relationship, which could be seen as contradictory to the notion of collaboration. Messari and Hallam (2003) found one of the main discourses described by clients when discussing their experiences of CBT for psychosis was 'CBT as a respectful relationship between equals'. This was accompanied by less collaborative and seemingly inconsistent discourses such as 'CBT participation as compliance with the powerful medical establishment', emphasising the complexities of this construct. These findings highlight that a more nuanced interpretation of the role of collaboration is called for.

There is a dominant discourse within the literature that collaboration is fundamental to CBT for psychosis, particularly within formulation. This construct is often presented as straightforward and sources reviewed did not acknowledge complexities, challenges or inconsistencies around this construct. CBT emphasises the remediation of irrational beliefs or cognitive errors residing within the individual (Anderson, 2005) and assumes that the therapist has the knowledge about how to think in a more helpful way, based on research evidence (Proctor, 2002). Despite the emphasis on 'collaboration' within CBT literature, these underlying assumptions can be used to discount or challenge the views or feelings of the client (Proctor, 2002). These can be seen to offer the therapist more power in the relationship which is legitimised with the appeal to the rationality of science and knowledge of the therapist (Proctor, 2002).

Notions of collaboration, as expectations that the client will contribute to the therapist's ideas and plans for treatment have been criticised for seeming to incorporate a demand that the client will conform to the therapist's approach and agree to tasks suggested (Proctor, 2002). Lowe (1999) argues that equality, as promoted by the notion of collaboration is impossible within the context of therapy due to the power inherent in the therapist's role. Lowe further argues that discourses of collaboration actually conceal the power of the therapist, thus increasing this power. The idea of 'guiding' clients to their own answers as described within CBT has been suggested to omit a level of the

therapist's power, as the therapist 'guiding' the client to a helpful outcome involves shaping the client's decisions (Proctor, 2002).

This study aimed to investigate collaboration within formulation in CBT for psychosis using discourse analysis. Such contested and variable concepts lend themselves to study by discursive methods. Formulation is an ideal site for talk about collaboration as within this process, particularly with clients experiencing psychosis, there is the potential for tension and difference of beliefs. Clinical psychologists who often see clients with complex presentations and are specifically trained in formulation were deemed a good source of talk regarding this topic. A discourse analysis can highlight constraining effects of dominant discourses by deconstructing these, open up the way for more empowering discourses and inform novel interventions (Georgaca & Avdi, 2012). This study aimed to investigate whether tensions were apparent in participants' talk and how these were managed, how collaboration was constructed, discourses drawn upon, and discursive strategies utilised.

Methodology

Foucauldian Discourse Analysis was utilised according to the guidelines of Willig (2008). This approach is concerned with language and its role in constituting social and psychological life, its relationship with subjectivity, and practice and power beyond the immediate context. Willig's approach also draws on Discursive Psychology (Potter and Wetherell, 1987); this pays attention to action orientation in talk, for example ways in which speakers manage issues of interest and stake.

Further details regarding methodology can be found in the extended paper.

In line with the method used a social constructionist stance is taken for the research; that is reality is seen to be constructed and maintained through systems of meaning and through social practices (Georgaca & Avdi, 2012). Interviews were conducted as this provides opportunities for the researcher to engage with participants, explore accounts given (Griffin, 2007) and enables the same topics to be covered with each participant. The use of interviews in

discourse analysis has been contentious topic with some advocating the use of naturally occurring talk (Potter & Hepburn, 2005). Others suggest that 'bias' in interviews is theoretically interesting and should be celebrated (Speer, 2002). Within this study meaning is viewed as jointly constructed by researcher and participant and accounts are viewed as a piece of interaction rather than a neutral resource (Speer, 2002).

Participants

Participants were 12 clinical psychologists from 3 participating NHS trusts who reported using cognitive-behavioural formulations with clients experiencing psychosis. Participants worked in a range of services including community mental health; inpatient; secure and forensic; early intervention in psychosis; assertive outreach; and crisis resolution.

Procedure

Clinical psychologists known to work with this client group were identified through contact with a collaborating clinical psychologist in each trust. Invitation letters *(see Appendix A)* and information sheets *(see Appendix B)* were sent to potential participants. Ethical approval was granted by the University of Lincoln (*See Appendix C*) and participating trusts *(see Appendices D, E, & F).*

Prior to conducting the interview, principles of anonymity and right to withdraw were outlined and participants were offered the opportunity to ask questions before signing the consent form *(see Appendix G)*. Participants were also asked to provide written information *(see Appendix H)* for example, service worked in, time since qualifying, and whether advanced training in CBT or formulation had been completed. Semi-structured, audio-recorded interviews lasting between 30 and 120 minutes were then conducted and transcribed verbatim (*see Appendix I for transcription system*). The interview schedule *(see Appendix J)* covered topics including participants' conceptualisation of CBT formulations, ways in which CBT formulations are developed and used when working with clients experiencing psychosis, how collaboration is promoted during formulation, and challenges in this process.

Analysis

Following transcription, several readings of the texts were undertaken along with an initial coding in which extracts viewed as relevant to the research question were selected, in line with Georgaca and Avdi's guidelines (2012). Willig's (2008) six stages were used to guide analysis and involved considering: 1) constructions of discursive objects, 2) discourses drawn upon, 3) function of talk within the interview, 4) subject positions adopted, 5) relationship between discourse and practice, and 6) relationship between discourse and subjectivity.

Analysis and Discussion

The analysis in this paper focuses on two significant discursive characteristics salient across accounts. First the diverse ways collaboration was constructed and second, the way speakers frequently justified deviations from the ideal of collaboration. In the extracts presented, 'I' indicates the interviewer is speaking, and 'P' indicates the participant is speaking. For a key of transcription symbols please see Appendix I.

Additional analysis and discussion can be found in the extended paper.

Constructing Collaboration

Collaborative formulation was constructed in two main ways: 1) developing the formulation with the client, and 2) sharing the formulation post-development and requesting feedback. Speakers commonly aligned themselves with collaboration, drawing on discourses of collaboration as the ideal. Participants presented collaboration as both straightforward and complex. The following extracts illustrate these features.

Excerpt 1 (Marie)

1. **I:** And is that (.) are both of those formulations ones that are developed
2. and shared with the clients
3. **P:** <u>Absolutely</u> yes (.) they're done collaboratively so you would typically
4. do them with the client (.) or certainly you'd go back and share that with
5. the client and <u>reformulate</u>

6. **I:** Yeh and so would that be what you would tend to do then (.) sort of
7. develop a formulation and go through it and then reformulate or would
8. it be to go through the whole process together
9. **P:** You could well you would share the formulation you would talk about
10. what your initial formulation would be with the client and possibly draw
11. it up together or you may come away and do that separately and then
12. take it back to the client to present it (.) and share that and agree your
13. understandings and then reformulate that

Analysis of this extract produced three key points. First Marie appeared careful to align herself, in the interview at least, with collaborative formulations. Marie replies *"absolutely yes"* (with emphasis) when asked whether formulations are "*developed and shared with"* clients and re-iterates this through description of *"do[ing] them with the client"* (lines 1-4). The use of such categorical assertions can be seen as a way of positioning herself in the interview and demonstrating commitment to a collaborative approach (Katriel & Dascal, 1989). The words *"or certainly"* construct that *"go[ing] back and shar[ing]"* the formulation with the client post-development is the minimum level of collaboration acceptable (line 4). This illustrates the second point, that collaborative formulation is constructed as having multiple layers.

Third, the certainty of terms used contrasts with the ambiguity of the version of collaboration presented. This is evident in the shifting description of collaboration described above. Drawing up the formulation together with a client is described as something Marie would *"typically"* and later only *"possibly"* do (lines 3, 10) whilst she more consistently refers to *"sharing"* it (lines 4, 9, 12) and *"reformulat[ing]"* (lines 5, 7, 13). Reformulating is constructed as a critical point of collaborative formulation where client comments are incorporated into initial ideas produced by the psychologist. This process of reformulation is not unpacked in the interview lending a second veil of uncertainty as to the detailed practice of collaborative formulation.

Excerpt 2 shares many features with excerpt 1 as discussed below.

Excerpt 2 (Harry)

1. **P:** And if you don't have that shared understanding if they're not buying
2. what we're selling then they're not going to do it (.) they're not going to
3. do it or it's going to have no you know it's just going to have no impact
4. because the explanation and therefore the treatment that we've
5. actually told them we're going to do will have no intrinsic worth or value
6. to them (.) so the idea of checking out your formulation it's fundamental
7. If you're not working collaboratively and if you're not checking out your
8. formulation with your client then to my mind you're not doing CBT (.) I
9. don't know what you're doing but it's it might be cognitively informed
10. but if we're not doing that basic thing then you're not doing cognitive
11. behavioural therapy
12. **I:** And how do you ensure that the formulation is collaborative and shared
13. with the client
14. **P:** I always tell them (.) I tell them what I'm thinking it's straightforward I
15. just tell them what I'm thinking (.) I ask you know I ask for their
16. feedback (.) I ask for their feedback on it (.) so I just I basically share it
17. with them I just tell them what I'm thinking and I allow them to I sort of
18. allow them to you know give to give feedback on it (.) and they have
19. obviously they have an alternative you know (.) if they disagree with
20. your formulation (.) I suppose you have to be careful because obviously
21. your formulation might be accurate or their rejection of the formulation
22. could still be an avoidance (.) it might not be (.) but it might be an
23. avoidance behaviour (.) and so it might be actually part of the problem
24. that they're coming for treatment with

Harry constructs collaboration as fundamental to CBT on lines 7-8. Furthermore, he describes not collaborating as leading to the formulation having "*no intrinsic worth"* (line 5). This negative case conceptualisation (Pomerantz, 1986) emphasises the importance of collaboration and positions Harry as aligned with collaborative formulations. This is strengthened by later statements accounting for transparency with clients: *"I just tell them what I'm thinking"* (lines 14-15). Collaboration is initially constructed as *"straightforward"* and "*basic"* (lines 10, 14), as in the previous extract this construction quickly becomes more complex.

Collaboration is described as developing a *"shared understanding*" (line 1) through *"checking out"* (lines 6-7) with the client leaving it unclear as to how this is formed precisely. The phrases *"buying what we're selling"* and *"allow[ing]"* feedback (lines 1-2, 16-17) interestingly positions the client as a consumer rather than producer of formulation.

Harry notes the possibility of client disagreements being *"avoidance behaviour"* or *"part of the problem"* (lines 22-23), drawing the listener's attention to the client's difficulties. This positions Harry as holding specialist knowledge. Harry's own formulation is alternatively described as *"might be accurate"* (line 21). This rhetorical strategy discredits the client's disagreement whilst justifying his own account. Modal auxiliaries such as *"might"* (lines 21-23) may act as a discursive strategy to position Harry as tentative and inoculated of stake (Potter, 1996) building a plausible and less refutable account. This could be viewed as disempowering the client and begs questions as to the possibility of complete collaboration when client views are constructed in such ways. It has been suggested that mental health professionals may use rhetorical devices to persuade others of their unique qualities in order to advance social status (Rogers & Pilgrim, 2010).

Excerpts 1 and 2 illustrate participants' use of discursive strategies to position themselves as collaborators, drawing on wider discourses of collaboration as the ideal frequently presented in CBT for psychosis textbooks (e.g. Fowler *et al.*, 1995). Collaboration is initially described as straightforward before ambiguity and complexity are quickly introduced. This is inconsistent with simplistic accounts of collaboration offered in the literature. The accounts construct collaboration as multi-layered, ideally involving developing the formulation with the client, and at a minimum consulting with clients on the formulation and seeking feedback. This more frequently presented construction positions the psychologist as having more knowledge and power possibly drawing upon wider discourses of mental health professionals as experts with unique skills (as discussed by Rogers & Pilgrim, 2010).

Justifying Deviations from the Ideal

Despite frequently positioning themselves as collaborative, participants also commonly became engaged in justifications for times when they deviate from this ideal. The following extracts illustrate this.

Excerpt 3 (John)

1. **P:** I kind of (.) I'd been working with him and I've been trying to get
2. him to reflect on his experience in number one that the beams haven't
3. actually killed him (**I:** umm) (.) and number two that actually there are
4. times where he's been able to force past the effect of the beams as he
5. experiences them to do things that are important to him and there's
6. been no negative fallout (.) so I've been ea:::sing him into the idea that
7. the beams aren't as powerful AS his experiences (.) the auditory
8. hallucinations, the voices would have him believe (**I:** umm) now that's
9. as far as I can get him at the moment because he's had twenty years of
10. believing this (**I:** yeh) now if I then said actually it's because you had
11. everything in your life it was going in the right direction then it all fell
12. apart including the loss of your daughter (.) who died from drowning (**I:**
13. umm) that would be too much (.) no he needs to feel that actually
14. there's been a persecution against him (.) otherwise he has to sit and
15. look at the tragedy that he's experienced (.) while ever there's an
16. external enemy he can focus some of that emotional upset at that
17. external enemy so I guess what my idea is to actually build up his
18. sense of self efficacy in the face of those experiences (**I:** umm) rather
19. than actually strip away every coping strategy he's developed and
20. expose him as a vulnerable traumatized damaged human being that
21. would almost be unethical (**I:** umm) (.) I would see that as not almost
22. unethical (.) that's completely unethical

First, John's talk justifies non-collaborative practices i.e. not sharing the formulation openly. It is reported that it "*would be too much"* if John openly shared his formulation (described on lines 1-13. This is constructed as dangerous and is equated to *"strip[ping] away every coping strategy"* (line 19). On lines 21-22 John draws on discourses of ethical and professional responsibilities, shifting from the statement *"that would almost be unethical"* to

"*completely unethical".* This shift to stronger language further positions him as an ethical practitioner with responsibilities to protect the client.

Second, collaboration is constructed as *"easing [the client] into the idea"* (line 6) giving specific examples to demonstrate this (lines 2-3, 7-8). This constructs that John already has the *"idea*": that the client holds these beliefs as a defence against past tragedy and the agenda is to gradually share this with the hope that the client will move towards sharing this understanding.

Third, John positions himself as pragmatic in order to manage issues of collaboration along with ethical responsibilities. The statement that the client "*needs"* to feel "*there's been a persecution"* (lines 13-14) argues that it is helpful for the client to hold these beliefs even if John does not share these. John outlines two possible courses of action: sharing his own understanding constructed to have unhelpful and dangerous consequences (line 20) or not sharing this and focusing instead on building up resources and "*self efficacy"* (lines 17-18). Constructing these courses of action as polarised persuades the listener that actions reported are ethical and necessary, justifying the lack of openness about his own formulation.

Justification for less collaborative practices may serve as a way of reducing subjective discomfort given wider discourses of 'collaboration as the ideal'. This demonstrates an ideological dilemma (Billig *et al.*, 1988) facing psychologists holding contrasting constructions of collaboration as the ideal, as well as complete openness as dangerous and unethical. A new construction of collaboration is also presented here: as gradually easing the client into ideas.

Excerpt 4 (Peter)

1. **I:** And this overlaps slightly, but in what way would you say the cognitive
2. behavioural formulation has an <u>impact</u> on either the clients or staff (.)
3. so either directly or indirectly
4. **P:** Erm what impact (.) I think at its best it can (.) yeh it can help patients
5. feel understood erm (.) and I suppose help other members of the MDT
6. see how some things arisen or how something's been maintained (.)
7. I think at worst ((laughing)) they can be overwhelming because they (.)

8. depending on I suppose, the level of detail (**I:** yeh) erm I I think and I
9. I suppose I (.) flitter around in between this but I think we've got a duty
10. not to overwhelm patients with the detail (.) but as a consequence you
11. know there's decisions to be made about how detailed the formulation
12. is (.) and the ideal is a level of detail that is helpful which is you know
13. is a tautological description (.) but you can have over simplistic you can
14. have just the right amount (.) or you can have it look overwhelming (**I:**
15. yeh) you know where it's got too many too much stuff in it to the point
16. where it confuses the patient or the team say oh right so you're
17. saying he's a mess then (.) you know cause that's what the
18. formulation looks like (**I:** yeh) that's not a good thing to convey (.) it
19. needs to be if that's what if that's what your you know private
20. professional formulation is that's probably not the one that the team
21. that should be shared with the team (.) and certainly not with the
22. patient 'cause I think you know we have a duty to erm (.) convey
23. hope through formulations

Peter constructs holding *"private, professional"* formulations alongside *"shared"* formulations (lines 19-21). This depicts that multiple formulations may be held simultaneously; one which reflects Peter's personal understanding and another which serves a pragmatic purpose. Similar to John, Peter alludes to the dangers of complete openness stating that an *"overwhelming"* formulation (lines 7, 10, 14) should "*certainly not"* (line 21) be shared with the client. Speaking on behalf of staff and clients on lines 16-17 is a persuasive rhetorical strategy that adds weight to this argument. Highlighting risks in this way calls forth positions for psychologist and service-user that might seem at odds with collaboration and closer to a position of expert helper. Peter justifies this by drawing on discourses of professional and ethical duties (lines 9, 22). This positions Peter only as responsible for determining the appropriate level of detail, emphasised by using the term *"you"* rather than 'we' on lines 13-14.

The notion of a private, professional formulation is an interesting construct and possibly glosses over issues of non-disclosure and secrecy, which are alternative ways of constructing these reports. It forms an interesting

construction of collaboration as only being possible when paralleled by a hidden, non-collaborative process to keep it safe; a construction again described in extract 5. Similarities are seen with excerpt 3 as the participant positions himself as pragmatic about formulations shared; describing these as having a functional purpose for example *"to convey hope"* (lines 22-23).

Excerpt 5 (Emma)

1. **I:** And you said earlier about in terms of sharing the formulation with the
2. client you said sometimes the formulation might be something that just
3. happens more in the background and it might be something that's more
4. to help your thinking (.) erm how do you make decisions about whether
5. that's going to be a formulation that is shared with the client or whether
6. it's something that's (.) (**P:** I probably) more to sort of help your
7. thinking
8. **P:** Probably (.) maybe I didn't kind of put that in a way that I meant just
9. hearing you kind of feed that back to me how I might have said that (.)
10. erm I don't kind of keep it as a secret (**I:** no) kind of endeavour (.) again
11. it depends on the client if I think they're really ready and they can work
12. with that approach or they can hear some hypothesising questions (**I:**
13. yeh) I might ask a question around I'm just wondering but what about
14. this idea (.) and if they seem to if it fits for them we'll kind of write it
15. down and we start generating the formulation (.) from that perspective.
16. with clients who I maybe think aren't at that point but it's to help my
17. thinking erm then I might do that more in the background how I kind of
18. maybe introduce it to those clients who haven't been ready to think
19. about that formulation I will share my thinking with them (.) and be just
20. as simple as that really there's no kind of great science behind it

The analysis of this extract demonstrates three main features of talk. First is Emma's positioning of herself as transparent and collaborative. Emma reports *"shar[ing]"* her *"thinking"* with clients on line 19 and uses the word *"we"* on line 14 when describing the formulation development. On line 8, Emma backtracks from previous statements made earlier in the interview and equates not sharing formulations to having a *"secret endeavour"* (line 10) and distances herself from

this position of secrecy: *"maybe I didn't kind of put that in a way that I meant"* (line 8). Using the term 'secret endeavour' polarises this position, persuading the listener that this does not represent the participant's practice. This can be viewed as a way of positioning herself within the interview.

Second, similar to previous extracts Emma describes collaboration on line 20 as *"simple"*; emphasising this by stating *"there's no kind of great science behind it".* However the account offered also constructs collaboration as complicated and ambiguous. For example Emma accounts for times when collaboration and transparency are not possible despite clear attempts to position herself as a collaborator. Emma claims that hypothesising questions and ideas are shared only when the client is "*really ready"* (line 11).

Third, the account constructs that there are occasions when a client is not ready and formulations may not be shared, for example *"with clients who I maybe think aren't at that point... I might do that more in the background"* (line 16-17). The phrase *"in the background"* was used by the interviewer (line 3) following the participant using this phrase earlier in the interview; repetition of this phrase may have influenced Emma to continue using these terms however. Non-collaborative talk appears to be troubling territory for this participant; this is shown overtly when she disputes the interviewer's characterisation of her position (lines 8-10) and is implicit in the elaborate account of how formulations might be shared.

The construction of holding multiple formulations in extracts 4 and 5 in order to demonstrate collaboration again draws on discourses of complete openness and collaboration as unhelpful, dangerous or unethical. Extracts 3, 4 and 5 all position psychologists as responsible for clients' welfare and highlights challenges for psychologists managing contrasting notions of collaboration and equality, with professional and ethical duties. Rogers and Pilgrim (2010) have commented on the ethical propriety implied by the term 'professional'.

Conclusions

This study illustrates the diverse constructions of collaboration presented and multiple positions adopted within clinical psychologists' talk about formulation in CBT for psychosis. The construction of 'collaboration as the ideal' was particularly salient along with participants positioning themselves as aligned with this ideal, suggesting that this discourse dominant in the literature has been adopted by clinical psychologists. Variations of collaborative formulation were constructed. Formulations co-produced between psychologists and clients were presented as the ideal level of collaboration, with formulations that were developed by the psychologist but shared and checked out with clients presented as the minimum level of collaboration or 'collaboration light'. Less dominant constructions of collaboration included a gradual persuasion of the client into the psychologist's ideas and developing multiple formulations. Furthermore collaboration was presented as straightforward alongside inconsistent accounts depicting this as complex and ambiguous. This adds to our understanding of collaboration within this context by demonstrating that collaboration can be viewed as a range of approaches, all with different outcomes for power relations, rather than a singular way of working.

Participants were keen to position themselves as equal collaborators and frequently minimised or omitted their position of power within accounts. Despite this, language used also constructed the psychologists as knowledgeable experts, working to help the client and therefore in a position of power within the relationship. The lack of openness and acknowledgement of these power differentials calls for such issues to be highlighted both within the profession of clinical psychology and CBT. It has been suggested that discourses of collaboration can conceal the power of the therapist (Lowe, 1999). Common discourses of collaboration need to be questioned and there is a need for more acknowledgement and openness of the limits of collaboration, and power inherent within the role of the therapist. By acknowledging such issues explicitly through supervision, training and within the CBT literature, measures can be taken to monitor use of power and ethical dilemmas arising. The findings indicate that current textbook understandings of collaboration as a singular

concept (e.g. Morrison *et al.*, 2004) are inadequate, and adds support for literature calling for a more subtle understanding of collaboration (e.g. Overholser, 2011).

Participants frequently justified deviations from this ideal of collaboration drawing on a range of discourses such as 'ethical and professional duties to protect clients' and 'dangers of complete collaboration and transparency'. This links to literature suggesting dangers of emotional arousal for clients with psychosis (Fowler *et al.,* 1995) and highlights tensions between discourses drawn upon. Discursive strategies used by participants to excuse client disagreements further highlight tensions between discourses of 'clinical psychologists as experts with knowledge and skills in formulation' (e.g. Kinderman & Tai, 2007) and discourses of 'developing a shared understanding through collaboration'. This is also consistent with literature suggesting challenges for collaborative formulation in CBT for psychosis due to wide gap between therapist and client views of the world (e.g. Tee & Kazantis, 2011). Participants managed such tensions by positioning themselves as pragmatic, for example reporting developing formulations according to purpose and function.

Implications

Reflection and openness in supervision and training regarding the limits of collaboration, types of collaboration possible and challenges of achieving this, along with implications for power would be useful to clinical psychologists. It may be particularly beneficial to consider tensions between constructs of collaboration and the professional to service-user relationship, as well as ways of managing disparity between practitioner and client beliefs, and challenges of collaboration within involuntary contexts. The risks of continuing to promote a simplistic version of collaboration may mean that practitioners report collaborative working to fit with this ideal without having the opportunity to make more explicitly informed decisions about collaborative formulation practice. Furthermore, reflecting on and increasing awareness of inconsistencies within discourses can help psychologists develop sincere relationships with clients within which they can accept and be honest about the type of collaboration that

may be most helpful for the individual. Openness about this topic can help navigate a way through this complex terrain.

Additionally, research seeking to unbundle collaboration from the working alliance and investigate the value this adds to CBT for psychosis is called for. Research from a service-user perspective on openness and transparency within CBT for psychosis would also be a beneficial addition to this study.

Limitations

Limitations of the study include the use of interview data; although this was helpful to focus participants on the topic of study, future research may add to this understanding by also investigating clinical psychologists' discussion of formulations in CBT for psychosis in naturalistic ways. For example, recordings of therapy sessions could offer an alternative perspective of how collaboration is discursively constructed. This study only considered collaboration as discussed by clinical psychologists, however as CBT is an inter-disciplinary approach further research investigating this construct within other professional groups using CBT for psychosis would be useful to explore whether constructions differ between these groups. Additionally, this was a social constructionist study and therefore relies on the assumption that language is constitutive of experience and action but does not make claims that this can inform us about what is really happening in practice.

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EXTENDED PAPER

EXTENDED BACKGROUND

Alongside family work CBT is arguably the most significant psychological intervention for psychosis, which can be a debilitating psychological difficulty. Formulation and collaboration are central to CBT but under-researched and conceptually ambiguous. CBT for psychosis is thought to require more careful attention to collaboration given the nature of the problems addressed. Formulation is arguably a very important location for collaboration because it forms the basis for agreement on how to work and what to work on, which is the heart of CBT. It is also a point where contested accounts of beliefs or experiences are likely to be brought into clear focus. This section will therefore present and discuss the literature around psychosis, CBT, formulation, and collaboration in order to demonstrate the rationale for the study.

Psychosis

There is no universally accepted definition of psychosis, with narrow conceptualisations including just hallucinations and delusions and broader conceptualisations including disorganised speech or catatonic behaviour (American Psychiatric Association [APA], 1994). The term 'psychosis' as used in this thesis refers to unusual perceptual experiences such as hearing voices, and unusual beliefs. Those who experience psychosis may be given a diagnosis of 'schizophrenia' therefore the literature regarding schizophrenia is also considered here. Hallucinations and delusions can be caused by delirium or general medical conditions including neurological, endocrine, and autoimmune conditions, or can also be the direct physiological effect of a substance (APA, 1994). This thesis does not focus on medical or drug-induced psychosis and the literature drawn upon tended to exclude this presentation and instead often focused on those with a diagnosis of 'schizophrenia' which according to diagnostic criteria excludes disturbance due to general medical condition or substance use (APA, 1994).

Psychosis as discussed here is situated within a Western cultural context in which a dominant discourse of unusual experiences as medical and pathological prevails. Research has found however that a number of people

experience ‘psychotic symptoms’ such as hearing voices yet do not ever come into contact with mental health services, perceive they can handle the voices, and can even feel enriched by these experiences (Romme & Escher, 1989). This paper concluded with recommendations for mental-health practitioners, for example: to accept people’s experiences of the voices; try and understand the person’s language used to explain their frame of reference; to consider helping the person to communicate with the voices; and to encourage those with unusual experiences to meet others with similar experiences to reduce isolation. These once radical suggestions can be seen as playing a large role in the movement towards collaboration and recovery now frequently promoted in mental-health services. Findings that it is people’s constructions or appraisals of the voices that determine how well they are able to cope with these, rather than the experiences per se has been supported by more recent studies (Chadwick & Birchwood, 1994; Morrison, 2001). Such interpretations of these experiences can be influenced by culture, with suggestions that positive attitudes towards hallucinations in some developing countries reflects philosophical perspectives that differ from those dominant in the West and is reflected in different rates of reporting hallucinations across different cultures (Bentall, 2003). The research described in this thesis that refers to people with psychosis tends to refer to those who have come into contact with mental health services and are therefore likely to have been experiencing distress or difficulty coping with these experiences. It is acknowledged that findings and conclusions drawn may not be representative of a number of people who experience unusual perceptual experiences or beliefs but for whom this is not associated with distress or contact with services.

Until recently, schizophrenia was seen to be a biological disorder (Tarrier, 2006) and psychologists and psychiatrists have historically been pessimistic about treating psychosis with anything other drug treatments (Morrison, Renton, Dunn, Williams & Bentall, 2004). The dominant paradigm then moved to a stress-vulnerability model (Nuechterlein & Dawson 1984; Zubin & Spring, 1977) assuming biologically vulnerable individuals become psychotic when exposed to stressful life events. More recently, psychological understandings of unusual beliefs and experiences have been constructed, along with psychological

treatments (Morrison *et al.,* 2004). Symptom based approaches to research has increased: considering specific psychological mechanisms associated with particular experiences. For example, research into auditory 'hallucinations' suggests these experiences may occur when an individual misattributes their own thoughts or inner speech to external sources (Mechelli *et al*., 2007). Studies looking at possible causal mechanisms involved in the development and maintenance of 'delusions' from a cognitive perspective, have included consideration of reasoning and attributional biases, as well as theory of mind difficulties (Garety & Freeman, 1999). Although symptom approaches offer a framework for understanding, the clinician must take into account idiosyncratic aspects of a person's personal history and life experience (i.e. formulation) as many service-users in mental health settings have multiple symptoms (Morrison *et al.*, 2004).

Cognitive Behavioural Therapy

It is reported that medication is still the mainstay of treatment for those diagnosed with schizophrenia (Jones, Hacker, Cormac, Meaden, & Irving, 2012). However a significant number of those treated with antipsychotics either do not respond or experience unpleasant side effects, although these side effects are somewhat reduced in newer versions of the drug (Bhattacharjee & El-Sayeh, 2008). Cognitive Behaviour Therapy (CBT) is now a recommended treatment for those diagnosed with schizophrenia (National Institute of Clinical Excellence [NICE], 2009) and a formulation based approach is advocated (Morrison *et al*., 2004).

CBT developed from the work of cognitive theorists such as Beck (1963; 1964) and Ellis (1962) who proposed that thoughts and beliefs play a role in the development and maintenance of distress. Ideas about the interaction between behaviours and cognitions from the self-instructional training literature (Meichenbaum, 1977) were also influential, along with research indicating the effectiveness of exposure and systematic desensitisation techniques (Wolpe, 1968). CBT is not a single approach rather it encompasses a variety of approaches and models that share core principles, that is that emotional and behavioural reactions are influenced by a person's thoughts, beliefs and

interpretations and that through learning processes such as reinforcement and conditioning, behaviours are instrumental in maintaining or changing a person's psychological state (Westbrook, Kennerley & Kirk, 2011). Other basic principles of CBT include that cognitions, emotions, behaviour, physiology and the environment interact with one another to form complex feedback processes; that mental health problems exist on a continuum and are exaggerated versions of normal processes; that the focus should be on current difficulties; and theories and treatments should be scientifically evidenced (Westbrook *et al*., 2011). Formulation and collaboration, as well as the therapeutic alliance are seen as central components in CBT (Beck, 2011).

There are a number of CBT formulation models, such as Beck, Rush, Shaw, and Emery's (1979) cognitive conceptualisation which links early experiences with core beliefs, rules and assumptions, suggesting a critical incident acts as a trigger for these, and negative thoughts then interact with feelings and behaviours to maintain the distress. Other CBT models e.g. Greenberger and Padesky (1995) focus on the current relationship between thoughts, feelings, physiology and behaviours. Ellis' (1962) ABC model (antecedent, belief, consequence) places more emphasis on the context of the specific situation and interpretation of this. Suggestions have been made as to what constitutes a 'good' CBT formulation such as having treatment utility, being parsimonious and evidence-based (Persons & Tompkins, 2007). Persons (1989) suggests several roles of cognitive case formulations in clinical work, including guiding intervention, facilitating the clinician to treat and understand unusual problems not previously encountered, and helping the therapist to understand and manage difficulties that arise within the therapy including failure to do homework or difficulties in the relationship. These roles are noted to focus more on therapist than client needs however.

CBT for psychosis

In CBT for psychosis links are made between a person's thoughts, feelings and behaviours. Clients are encouraged to use techniques such as challenging habitual patterns of thinking, looking at evidence for and against distressing beliefs, and reasoning to develop rational and personally acceptable alternative

explanations (Alford & Beck, 1994). Birchwood and Trower (2006) suggest that CBT should target emotional and behavioural distress rather than psychotic symptomology. As different mechanisms may be involved the development of different symptoms relating to psychosis it is suggested that clients' problems should be viewed in terms of the specific symptoms experienced, the impact of these and the psychological mechanisms behind these symptoms (Morrison *et al.,* 2004). It is reported there can be difficulties engaging people experiencing psychosis in therapy, especially when experiencing paranoid and persecutory delusions (Morrison *et al.,* 2004). Associated problems such as depression or substance abuse may arise prior to, or even contribute to the experience of psychosis, or as a consequence of the stigmatising perceptions of psychosis held in society (Morrison *et al.*, 2004). Those with persecutory delusions may be distrustful or suspicious of their therapist and this may be heightened if the service-user has had experiences in which they have lacked power and control within relationships with mental health professionals, for example being detained under the Mental Health Act (2007). This highlights the importance of building a therapeutic alliance prior to commencing assessment, formulation and intervention and taking a collaborative and transparent approach. Sivec and Montesano (2012) review elements of CBT for psychosis and discuss differences to CBT for other disorders. They found CBT for psychosis textbooks further emphasise the need for engagement; providing shorter, more informal sessions; and not pushing challenging beliefs. Normalising experiences was also reported to be seen as key, as well as facilitating clients to develop their own conclusions about beliefs and perceptions through techniques such as socratic questioning, enabling development of coping strategies, and using behavioural experiments.

Much evidence for CBT for psychosis is based on research into its efficacy; that is interventions have been conducted under optimal conditions involving well selected participants, structured treatment manuals and strict exclusion criteria (Lincoln *et al.,* 2012). Research considering the effectiveness of CBT for psychosis i.e. investigating its effects in real world conditions, have shown mixed results. Morrison *et al.* (2004b) found improvement in positive symptoms and depression compared to wait-list control. However, effectiveness studies

using randomisation demonstrated no significant advantage of CBT over wait list control (Farhall, Freeman, Shawyer & Trauer, 2009; Peters *et al.,* 2010). A recent study investigating the effectiveness of CBT for psychosis in routine practice, using less stringent exclusion criteria, therapists with normal caseloads, and not monitoring adherence to treatment manuals or restricting session numbers, found the CBT group showed significant improvements over the wait-list group in terms of positive and secondary symptoms such as depression and functioning (Lincoln *et al*., 2012). These findings were supported by another recent randomised study investigating the effectiveness of CBT for psychosis compared to a wait-list control in routine practice (Kråkvik, Gråwe, Hagen & Stiles, 2013). Research has also demonstrated the effectiveness of CBT for psychosis in reducing symptoms in those not taking antipsychotic medications (Morrison *et al*., 2012).

A large review of research investigating CBT for psychosis in clinical practice (Sivec & Montesano, 2012) found that CBT for psychosis demonstrates a modest but positive impact for positive symptoms. The findings suggested no clear evidence that CBT provides significant advantage in preventing relapse, but results suggested clients who received CBT spent less time in hospital than controls. The review also suggested high client satisfaction with this approach; for example in one study (Durham *et al.,* 2003), 70% of those who completed CBT reported that the treatment was positive and helpful compared to 30% in the treatment as usual group and 37% of the supportive therapy group. The authors conclude that it is unclear as to the specific reasons for high satisfaction reported. The majority of studies have compared CBT to standard treatment or wait list controls. A review of 20 studies investigating the effects of CBT compared to other psychosocial treatments for schizophrenia (Jones *et al.*, 2012) found no difference in global mental state, adverse affects, relapse or rehospitalisation rates. It can be concluded that although the evidence suggests a consistent advantage for CBT compared to waiting list controls or treatment as usual; there is not a convincing and clear advantage for CBT over other therapies.

Formulation

A psychological formulation developed collaboratively with the client is considered a fundamental component of CBT for psychosis (Morrison *et al*., 2004). Formulation and the literature regarding this construct in general, within CBT and specifically CBT for psychosis will now be considered. Several definitions of formulation exist including "a hypothesis about the causes, precipitants and maintaining influences of patients' psychological, interpersonal and behavioural problems" (Eells, 1997, p.1); and "a provisional map of a person's presenting problems that describes the territory of the problems and explains the process that caused and maintains the problems" (Beiling & Kuyken, 2003, p.53). Definitions have been synthesised to describe formulation as "a hypothesis about a person's difficulties, which links theory with practice and guides intervention" (Division of Clinical Psychology [DCP], 2011, p.2). Formulations bring together assessment information to explain a client's problems in order to plan appropriate intervention and facilitate the client's understanding of their experience (Johnstone & Dallos, 2006).

Good practice guidelines for clinical psychologists advocate formulations are: constructed collaboratively, accessible, concerned with personal meaning, useful, person-specific, integrative, and include a cultural and societal perspective (DCP, 2011). Despite a lack of research to support the superiority of individualised approaches, it is advocated that formulations should be based on individual experiences rather than psychiatric diagnosis (DCP, 2011) challenging formulation models based on psychiatric diagnosis. It has been suggested that this ability is unique to clinical psychologists drawing on a wide knowledge base, trained to be able to critically evaluate, analyse and synthesis psychological information from a psychological perspective, and to communicate this information effectively to service users, carers and professionals (DCP, 2010). Furthermore, the ability to develop psychological formulations is a required competence for clinical psychologists (Health & Care Professions Council [HCPC], 2012; DCP, 2010). Despite grand claims about the role of collaborative formulation in clinical psychology, there is insufficient evidence to support these and little is known about how clinical psychologists construct concepts of formulation and collaboration.

Use of formulation varies between therapeutic traditions. Some approaches such as narrative and humanistic, which move away from linear cause and effect paradigms do not use traditional formulations, viewing the development of such as imposing an expert position on a client's experience (Johnstone & Dallos, 2006). For other approaches, particularly those commonly used by clinical psychologists in the NHS such as cognitive-behavioural, systemic, psychodynamic and cognitive-analytic it is seen as a key component (DCP, 2011). Formulations can differ between approaches in terms of explanatory concepts drawn upon, factors seen as most relevant, position in relation to diagnosis, 'truth' versus 'usefulness', and degree to which an expert position is adopted (Johnstone & Dallos, 2006).

A formulation can be developed for differing levels of a client's difficulties e.g. whole case, problem, symptom or situation (Grant, Townend, Mills & Cockx, 2008). Formulations may be more or less comprehensive as appropriate for the purpose and could focus on a complex set of difficulties in the context of the whole life story or constitute a simple diagram demonstrating how thoughts lead to anxiety and then avoidance, which may be more suitable for routine clinical practice (DCP, 2011). This suggests there may be significant variation in what constitutes a formulation.

The role of formulation is varied and includes prioritising issues and problems, clarifying hypotheses and questions, increasing understanding, determining criteria for successful outcomes, and potential barriers (Butler, 1998). Formulation is thought to be important for deciding upon appropriate intervention, as well as being viewed as an intervention in its own right, by helping the client feel understood, offering hope and strengthening therapeutic alliance (Butler, 2006; DCP, 2011). Given the variation in definitions of formulation, the way in which it may be used, and views of its role, it is unsurprising that research has had difficulties evaluating this phenomenon. There is a paucity of research looking at how formulations are developed and used in practice, however a recent study (Christofides, Johnstone & Musa, 2012) found that clinical psychologists most often shared psychological hypotheses with multidisciplinary teams through informal means such as

'chipping in' ideas during discussions, rather than formal case presentations or training. This highlights the variable and often implicit nature of formulations with teams, and has implications for research attempting to evaluate formulations using reliability criteria or trying to determine its impact on outcomes.

It has been suggested formulation has the potential to be used in disempowering and insensitive ways (Johnstone & Dallos, 2006). Crellin (1998) suggests an attempt to formulate a client's problems according to a theory unavoidably "totalizes and reduces", reporting "formulation is either never appropriate or only possible at the end of a long therapy" (p.26). Causal factors often neglected or minimised in formulations include transference and counter-transference (Meadon & Van Marle, 2008), personal meaning (Leeming, Boyle & Macdonald, 2009), the influence of stigma and discrimination, and consequences of the 'mental patient' role (Barham & Hayward, 1995). Furthermore psychological formulations can be limited by the influence of personal bias (Kuyken, Padesky & Dudley, 2009), client difficulties asserting disagreements (Johnstone, 2006), failure to consider cultural and political context (Brooke, 2004), minimisation of the experience of medical interventions (Martindale, 2007) and the role of trauma and abuse in psychosis (Moskowitz, Schafer & Dorahy, 2008). It is reported such limitations may be overcome by working collaboratively with service users, using everyday language, emphasising strengths, using supervision, and reflecting on personal assumptions (DCP, 2011).

Formulation in CBT

A review of the evidence to support cognitive case formulations (Bieling & Kuyken, 2003) found evidence to support some of the constructs underpinning cognitive formulation such as the situation-emotion-thought-behaviour process, links between early life adversity and psychopathology as well as the idea of core beliefs. However, limited evidence was found to support the notion of conditional assumptions or the connection between specific cognitions and coping strategies (Bieling & Kuyken, 2003). The review found less support for 'bottom up' criteria; reliability was demonstrated in descriptive but not inferential

aspects of the formulation and no compelling evidence was available to support formulations as meaningfully related to a person's problems, to link formulation to treatment outcomes, or demonstrate the utility of formulations to clients. However, this review focused on depression, anxiety and personality disorder and did not consider research for psychosis.

Research comparing outcomes of individualised, formulation-based approaches with standardised approaches do not offer compelling evidence for a formulation approach (e.g. Emmelkamp, Bouman, & Blaauw, 1994; Schulte, Kunzel, Pepping & Shulte-Bahrenberg, 1992). There is evidence that cognitive formulation may improve treatment selection (Addis & Jacobson, 2000; Jacobson *et al*., 1989). Tarrier and Calam (2002) report that these studies have been underpowered and potentially suffer from type two errors; and these studies considered primarily behavioural, rather than cognitive-behaviour interventions however.

Research investigating the quality and reliability of cognitive case formulations has found reliability in descriptive elements of the formulation but rates of agreement decreased for aspects requiring greater levels of theory-driven inference (Kuyken, Fothergill, Musa & Chadwick, 2005). These findings support previous studies (e.g. Mumma & Smith, 2001; Persons, Mooney & Padesky, 1995). Only one study is known to have investigated the reliability of cognitive formulations for clients with psychosis. The study (Dudley, Park, James & Dodgson, 2010) again found good agreement for overt behaviours such as physical symptoms, stressors, triggers, emotions and early experiences, but poorer agreement for theory driven components such as thoughts, core beliefs and assumptions. Dudley *et al.* (2010) state concerns that lack of agreement on the formulation may lead to lack of agreement as to what intervention will be most helpful to the individual which has a potentially profound impact on the client.

Multiple baseline design research has been conducted to determine the impact of case formulations in CBT for psychosis on client outcomes (Chadwick, Williams & Mackenzie, 2003). Self-reported strengths of delusional beliefs were rated by clients, and ratings of therapeutic alliance were completed by clients

and therapists. Interviews regarding client experience were also conducted. For clients, although scores on all measures improved throughout therapy, the effect of formulation specifically was not significant for any measure. Interview data for clients found contrasting positive and negative reactions to formulation. For therapists, formulation had a significant impact on increasing perception of therapeutic alliance and also increased confidence in CBT and understanding of clients. The findings cast doubt on either the utility of formulation based approaches in CBT for psychosis or on the criteria by which it is being evaluated. Participants were asked to complete the same measure four weeks in a row however; this could have lead to participants becoming tired of the questionnaire and may have affected the reliability of answers given. Secondly, the study only investigated immediate, short term effects of formulation. The study also assumes that formulation happens in a particular way i.e. explicitly shared in a developmental diagram and a letter as required by the design of the study.

These findings were supported by a later qualitative study which again found complex and contrasting positive and negative experiences of CBT formulation (with clients who experienced psychosis) which varied over time, concluding that overall reactions were equally negative as positive (Pain, Chadwick & Abba, 2008). Participants were asked to take part in the study immediately following the formulation sharing sessions. This may have negatively impacted on the clients' perceptions of therapeutic relationship and formulation experience. The mixed reactions to the explicitly shared written and diagrammatic formulation may indicate the importance of tailoring the method of communicating the formulation as well as type of formulation to the individual. This could also indicate the importance of developing a CBT formulation for psychosis gradually over time, as advocated by Kinderman and Lobban (2000). They recommend that the formulation should begin simply, with straightforward theoretical models which can then be gradually elaborated, developing layers of complexity. Again, the evaluation of explicit written formulation does not take into account that formulation may be implicit, embedded in therapeutic dialogue and reformulated indefinitely over several sessions.

Collaboration in CBT for psychosis

Collaboration is frequently stated as a fundamental part of CBT for psychosis and particularly within the formulation process. Collaboratively constructed formulations are also advocated in CBT formulation more broadly (Tarrier, 2006) and for all clinical psychology formulations (DCP, 2011). The literature on collaboration and particularly within CBT for psychosis will now be reviewed.

Therapeutic collaboration in CBT was first described by Beck *et al.* (1979) as a means of encouraging client identification, observation and evaluation of introspective beliefs. Collaboration is suggested to be particularly important when working with individuals with psychosis due to claimed difficulties with engagement in this client group. It has been reported that collaboration facilitates engagement and treatment adherence by making interventions meaningful and relevant from the client's perspective (Cameron, 1978). Early research indicated engagement may take longer and be more difficult with psychotic clients (Frank & Gunderson, 1990) however more recent research indicates that the therapeutic relationship developed with individuals with psychosis is comparable to those without (Dow, 2003 as cited in Evans-Jones, Peters & Barker, 2009). Recent research demonstrates that it is possible to develop good therapeutic relationships with clients experiencing psychosis within CBT, regardless of severity (Evans-Jones *et. al.*, 2009). The notion of collaborative formulation in CBT for psychosis may be more challenging in this setting due to more obvious discrepancies between client and therapist beliefs about the nature of experiences.

Despite claims made about collaboration, there is insufficient research investigating this topic. Tee and Kazantis (2011) comment on the lack of operational definitions and measures for Beck's construct of collaborative empiricism. Research has more often focused on the therapeutic alliance; Bordin's (1979) definition of a collaborative relationship has often been cited by researchers when describing both the working alliance and collaboration as though these are similar or overlapping constructs, and many working alliance measures are based on this definition. Bordin described three components as central to the collaborative relationship: mutual agreement on goals of therapy,

agreement on tasks and responsibilities, and personal bond. It is suggested however that the meaning of collaboration, of 'sharing the work' is not captured by Bordin's and others' conceptualisations of a collaborative relationship (Tee & Kazantis, 2011). It is currently unknown whether collaborative empiricism is related to treatment outcomes or whether it mediates cognitive change processes (Tee & Kazantis, 2011).

Research using a discourse analysis approach to look at clients' experiences of CBT for psychosis found one of the main discourses described was 'CBT as a respectful relationship between equals' (Messari & Hallam, 2003). However, this was accompanied by an alternative and seemingly inconsistent discourse described by a minority, of 'CBT participation as compliance with the powerful medical establishment' e.g. CBT participation was talked about as a way of facilitating discharge from inpatient services. This emphasises the complexities of collaboration within CBT, particularly for clients with psychosis who may be taking part in therapy within wider non-collaborative services where clients lack power. Therapists discourses within this study included 'CBT as a collaborative educational process' along with 'CBT as a modification of patient's paranoid beliefs' which alternatively constructed a less collaborative process in which therapists had an agenda to modify beliefs. This further highlights complexities and variability of collaboration and clinicians' constructions of this. Another recent study, led by service users (Kilbride *et al.,* 2013) also explored clients' perceptions of CBT for psychosis. Most participants referred to experiences of working through psychological formulations although only three identified structured formulations as a distinct technique. The majority of accounts described formulation implicitly, and highlighted the value of the therapist 'writing things down' and 'drawing diagrams' to facilitate understanding. The theme of normalisation emerged, with participants reporting that considering psychotic experiences within the context of life events was effective in improving understanding and offering a different perspective. Partnership and collaboration in CBT also emerged as a valued aspect of CBT for psychosis. Furthermore, participants reported valuing the accessible, informal, individualised, and flexible approach of CBT, as well as perceived client control such as in determining agenda and prioritising goals. Interpersonal engagement

was highlighted as essential in order to share experiences with the therapist. A number of participants compared CBT with previous experiences of mental health services, indicating the collaborative approach was novel to them. This indicates that collaborative formulation in CBT for psychosis is highly valued by service users.

This is contested however by other research that actually suggests collaboration, as viewed by service users, may not be as important as claims suggest. A phenomenological analysis of client descriptions of a 'good therapeutic alliance' (across a range of therapeutic approaches) resulted in three relatively distinct alliance types (Bachelor, 1995). A 'nurturant' alliance type was most commonly referred to (46% of reports) involving descriptions of a non-judgemental and empathic approach; this was followed by an 'insight-orientated' approach described in 39% of reports characterised by improved self-understanding through clarification of significant material. Finally, what was categorised as a 'collaborative' alliance was described in only 15% of accounts; this was characterised by active involvement in therapy and assuming responsibility for change. Given the majority of participants perceived a positive relationship as nurturing or insight-orientated, this does not support claims that active collaboration is a major determinant of alliance. However this study was not specific to CBT for psychosis. Although limited, preliminary qualitative studies suggest that with CBT for psychosis specifically, a collaborative approach to formulation is valued by clients.

Despite common discourses in the literature of the importance of collaboration in this context and this often being presented in a straightforward manner with positive case examples offering examples of collaborative case formulation (e.g. Fowler, Garety & Kuipers,1995) there are inconsistencies within the literature. For example, as well as promoting the development of a 'shared understanding' and working 'with' the client, textbooks also encourage 'appearing' open minded and uncertain if a client asks the therapist's view of the reality of their beliefs (Fowler *et al*., 1995). This construction of 'appearing' a certain way rather than actually 'being' open minded conversely implies a lack of openness with the client which seems inconsistent with the notion of collaboration. Other

inconsistencies with language used when talking about collaboration in CBT for psychosis include advocating the collaborative development of a formulation, as well as 'presenting' formulations to the client (Morrison *et al.*, 2004). As well as the role of collaborator, therapists are also encouraged to offer advice, training and psycho-education within CBT for psychosis; such roles seem to position the therapist as an expert and teacher which might undermine collaboration and lead to tension between psycho-educational components and collaborative empiricism. Furthermore, Overholser (2011) comments on difficulties in applying collaboration in a fluid manner when utilising a structured CBT treatment manual as often used within rigorous clinical trials.

Criticisms have been posed regarding the notion of collaboration within CBT. CBT has been described as a rationalist and empiricist approach which emphasises the correction of irrational beliefs or remediation of cognitive errors residing within the individual (Anderson, 2005). This approach assumes that the therapist has the knowledge about how to think in a more helpful way and that such knowledge is based on research evidence (Proctor, 2002). Such a focus on realism can be used to discount or challenge the views or feelings of the client (Proctor, 2002). The appeal to the rationality of science within CBT, and with this the therapist making judgements about what is rational or desirable has been criticised for imposing a 'socially conformist ideology' on the client (Spinelli, 1994, p.249) along with the neglect of wider social structural positions and material realities of power and oppression (Proctor, 2002). Despite the emphasis on 'collaboration' within CBT literature, these underlying assumptions can be seen to offer the therapist more power in the relationship which is legitimised with the appeal to the rationality of science and knowledge (Proctor, 2002). This approach of changing client's beliefs in favour of the therapist's notion of rationality is seen by some as opposed to more collaborative social constructionist perspectives that are respectful of multiple views and possible interpretations of a problem (Anderson, 2005).

Considering issues of power and collaboration within the therapeutic relationship is of importance, given criticisms that psychology gained its status with the development of psychological therapies that have been described as a

form of social control, with a function to 'normalise' individuals (Rose, 1985). Some authors have proposed that there is always a power imbalance within the therapeutic relationship, and that such power is inherently oppressive and abusive (e.g. Masson, 1989). Others agree that the therapist cannot eliminate the power inherent in their socially constituted role but argue that the aim should be to avoid domination in therapy by supporting the client's communication and ensuring reciprocal influence, by monitoring therapist's use of power through supervision and regulation and increasing the client's power outside of the therapeutic relationship (Fish, 1999). Such a power difference is not always viewed as inherently 'bad' however; Larner (1999) suggests that it is possible for therapists to use power ethically by taking an ethical stance towards the other. Larner suggests the therapist needs to be both powerful (against violation within ethical relation) and non-powerful (to allow the other to be heard).

Collaboration is reportedly a central tenant of CBT, particularly when working with those experiencing psychosis. Descriptions of collaboration, as expectations that the client will contribute to the therapist's ideas and plans for treatment have been criticised for seeming to incorporate a demand that the client will conform to and welcome the therapist's approach (Proctor, 2002). Lowe (1999) argues that equality, as promoted by the notion of collaboration is impossible within the context of therapy and the power inherent in the therapist's role. Lowe further argues that discourses of collaboration actually conceal the power of the therapist, thus increasing this power. The idea of 'guiding' clients to their own answers as described within CBT has been suggested to miss a level of the therapist's power, as the therapist 'guiding' the client to what a helpful outcome involves shaping the client's decisions (Proctor, 2002). Some CBT literature has positioned the therapist as holding "superior knowledge", stating that the authority of which should, at times be "exercised and accepted by the client" (Turnbull, 1996, p.20) demonstrating the power held by the therapist within CBT as the decision-maker with regard to therapy (Proctor). This has led to the argument that the notion of collaboration within CBT is often muddled with the notion of compliance (Proctor, 2002).

It is clear that the construct of collaboration within CBT is not straightforward and many complexities and tensions surround this discourse. This entices the question of whether complete collaboration is ever possible within the limits of a particular scientific framework (as contested by Lowe, 1999) and within a therapist-client relationship in which the practitioner has ethical and professional responsibilities to use most effective, evidence-based approach with a client.

No research to date has specifically addressed the issue of collaboration within the formulation process in CBT for psychosis, despite these principles being held as central to this widely used and NICE (2009) recommended approach, and specific challenges identified to working collaboratively with those experiencing psychosis. The literature highlights a lack of clarity regarding these concepts and sources reviewed do not take into account complexities around the notion of collaboration; with this ambiguous and variable concept often being presented in a straightforward way. This study will utilise a discourse analysis approach to investigate the ways clinical psychologists construct and talk about issues of collaboration within the formulation process in CBT for psychosis. Discussions of formulation can be viewed as a very important source for talk about collaboration, as this forms the basis for jointly deciding how to work with the person and can be a point where differences in views and understandings are likely to be brought to light. A discourse analysis approach allows for variability in the ways collaborative formulation may be discussed. Discourses are not only bodies of ideas but also courses of action and terms of reference immersed into social practices (Gubrien & Holstein, 2000). Inconsistency in talk can be productively investigated by taking a social constructionist perspective and considering ways in which collaboration is discursively constructed and how both local interactional and wider historical and social contexts may influence, and in turn be influenced by this.

EXTENDED METHODOLOGY

It has been suggested that when deciding what method of qualitative analysis to use, one should consider the nature of the research question as well as the researcher's own epistemological position (Harper, 2012). Consideration may also be given to the scientific interests of the reader, personal preference, researcher expertise, method popularity and relevance of method to target audience (Priebe & Slade, 2006). Qualitative approaches can provide thick, rich descriptions useful for exploratory research (Willig, 2008). Discourse analysis allows for the "multitude of divergent and conflicting voices with which scientists speak" to be set free instead of assuming there is a true and accurate version of participant's beliefs and actions (Gilbert & Mulkay, 1984, p.2). Such an approach was deemed helpful in investigating the abstract topics of formulation and collaboration which have been constructed in variable ways in the literature. This approach allows for such variability and views this as interesting rather than problematic.

The research question "How do clinical psychologists construct collaborative formulation within CBT for psychosis" was determined to be best addressed by a methodology that allows accounts to be deconstructed and situated within wider contexts. The study aimed to investigate ways in which collaboration and formulation are constructed in participants' talk, discourses drawn upon, whether tensions and inconsistencies are present and how these are managed, how actions related to these topics are accounted for and how participants position themselves and others within accounts. These goals were most suited to a discourse analytic methodology (Starks & Brown Trinidad, 2007) and this approach was thought to be particularly useful given the anticipated 'text book' responses that may be given in response to questions about these topics, and to enable such responses to be critically analysed. Discourse analysis has been used to investigate a number of topics relating to mental health and psychological therapy including ways in which professionals construct clinical cases and justify their practices (Stevens & Harper, 2007) and to deconstruct dominant medical discourses implicated in the construction of a person's identity within psychotherapy (Avdi, 2005). The research question would not be

appropriate for a phenomenological approach, aiming to understand the lived experience of the phenomenon under focus, or a grounded theory approach which aims to develop explanatory theory of social processes (Starks & Brown Trinidad, 2007). Furthermore, approaches such as thematic analysis are more appropriate for studies seeking to summarise unstructured data in thematic categories (Harper, 2012) and takes participants' accounts at face value, restricting opportunities to consider the influence of wider discourses on such accounts and the function of such accounts within the interview.

This research utilised a primarily Foucauldian Discourse Analysis (FDA) approach as outlined by Willig (2008). In this approach Willig attempts to draw together methodological strands from overlapping research practices in psychology and wider social sciences, developed in light of the work of Michel Foucault on the history and uses of knowledge. A full history of discourse analytic approaches is too broad to cover within the remit of this study; however a summary of the main approaches drawn upon are presented below.

Foucauldian Discourse Analysis

Central to FDA are concepts of discourse, power and knowledge (Carabine, 2001). Discourses are viewed from this approach as productive of the objects of which they speak e.g. sexuality or madness, and also in terms of power outcomes (Carabine, 2001). Discourses establish what is 'true' at any given time and can produce new ways of conceptualising an issue but also draw on existing and dominant discourses i.e. normative or 'common-sense' constructs (Carabine, 2001). Foucault (1991) argues that power is constituted through discourses and that power is implicated in the construction of knowledge and what counts as knowledge. Certain discourses can become more powerful and have more authority than others, therefore this version of discourse analysis is seen as "more than a study of language" (Carabine, 2001, p.275) and must also look at social relations and the social context in which knowledge and power are constructed and maintained.

Discursive Psychology

Discursive Psychology ([DP] Edwards & Potter, 1992) presents a re-conceptualisation of cognitive psychology in which people's accounts are taken to reflect their mental representations of the social world (Horton-Salway, 2001). This approach alternatively focuses on the constructive nature of descriptions rather than being concerned with possible entities behind these (Horton-Salway, 2001). The study of participants' talk focuses on how objects are described, how accounts are constructed and how cognitive states are attributed (Edwards & Potter, 1992). Such phenomena are analysed as 'discursive practices'. Actions are considered instead of cognitions, for example actions such as 'remembering' and 'attribution' are seen as functional, and issues of fact and interest, accountability and agency and how these are constructed and managed are investigated (Horton-Salway, 2001).

Critical Discursive Psychology (CDP) has similarities to FDA and broadens the focus to consider the historical context within which the interaction takes place (Edley, 2001). This recognises that when people talk they use a repertoire of terms which have been provided by history and that a language culture may provide a range of ways of constructing or talking about an object although certain dominant constructions may be more available than others (Edley, 2001). One of the aims of CDP is to analyse this procedure of normalisation and to ask about whose interests are served by different discursive formulations (Edley, 2001).

Synthesising approaches

Each of the above approaches has its limitations, for example DP assumes that speakers have a stake in their interaction and that they are capable of managing such stake through use of discursive action (Willig, 2008). This approach is unable to account for why these individuals or groups seek to practice particular discursive objectives, and limits its analysis of discourse to the specific text viewing that meaning is produced within the text (Willig, 2008). Furthermore, placing emphasis on the context of the interview interaction tends to neglect broader social and historical contextual factors (Willig, 2008). Foucauldian Discourse Analysis which takes a broader contextual perspective, aims to look at the relationship between language, human subjectivity and

social relations. However, conclusions drawn may miss the influence of the particular context on people's talk, functions of this and particular constructions. Furthermore this approach raises difficult questions such as the extent to which subjectivity can be theorised on the basis on discourse (Willig, 2008).

Wetherell (2007) advocates that traditional distinctions between DP, offering a detailed analysis of the action orientation of talk and FDA investigations of power, discourse and subjectification should instead be synthesised to form an eclectic approach which can provide a viable approach to discourse analysis for psychological projects. Descriptions of 'discourse analysis' often take into account local interactional orientation of talk as well as wider investigations of discourse and power and can be seen as integrating approaches of DP and FDA. Alvesson and Karreman (2000) comment on the many meanings of the term 'discourse' suggesting this can lead to confusion. Although they report there are two main approaches to the study of discourse: the study of social text or talk (in its social action context) and the study of social reality as discursively constructed and maintained, they also suggest a 'middle-range' approach is possible. This study takes a 'middle-range' approach paying attention to both functions of talk and how these are situated within the context of the interview, as well as within the wider social and historical context; subject positions adopted; and variability in talk to offer an understanding of these constructions not previously addressed by the research.

This approach to discourse analysis was deemed the most appropriate to construct useful findings which may be applicable to clinical psychologists working in similar contexts. For this study therefore, rather than using clinical psychologists' accounts as a resource to infer 'truths' about how formulation and collaboration happen in practice in CBT for psychosis, participants' talk and the way this is organised and produced to construct their actions and beliefs in the course of the interaction was treated as the topic of investigation. In this study language was not understood as a transparent or reflective information-carrying vehicle, rather as constitutive: the site where meanings are changed, created and situated within the process of an ongoing interaction (Taylor, 2001).

Willig (2008) offers a six stage model of what she names 'Foucauldian Discourse Analysis'; these guidelines for analysis were utilised for the present study (*Discussed further in Analysis section*). These clear guidelines were determined to be particularly useful for a novel discourse analyst and were useful to structure the analysis for this study. Unlike previously discussed descriptions of FDA which imply little interest in the local interactional business of talk analysis, the method described by Willig looks at both the immediate interactional context as well as wider discourses and can be seen as fitting closely with Alvesson and Karreman's (2000) description of a 'middle range' approach. This highlights that the many overlapping and fragmentary approaches to discourse analysis risk creating confusion, not least in the naming of approaches.

Epistemology

Epistemology is the philosophy of knowledge; it is concerned with questions such as "how can I go about gathering knowledge about the world?" and "how do I know what I know?" (Harper, 2012, p.86-87). Within qualitative research methods, a range of epistemological positions may be taken including realist, contextual constructionist and radical constructionist (Madill, Jordan & Shirley, 2000).

Realism or positivism holds a correspondence view of truth; that is truth is knowable and just as it appears to be (Madill, Jordan & Shirley, 2000). Critical realism instead postulates that our perceptions in a social context are influenced by beliefs and expectations; subjectivity plays a role in the production of knowledge (Madill *et al.,* 2000). Researchers adopting a contextualist or radical constructionist epistemology are more likely to reject notions of objectivity and reliability as criteria for evaluation of research (Madill *et al.*, 2000). From a contextualist position it is not assumed that there is one reality that can be known through utilisation of the correct methodology. Instead, it posits that knowledge is situation dependant and provisional; therefore results obtained through research will depend on the context in which data was collected and analysed (Madill *et al.,* 2000). Radical constructionism moves closer to challenging the notion that there can be any absolute foundations of

knowledge (Madill *et al.*, 2000). This position is distrustful of the view that language can represent reality; knowledge is considered to be constructed through language and social interaction and notions of truth or falsity are put to one side. Harper (2012) comments that social construction (similar to the previously described contextualist and constructionist positions) is relativist in the sense that it is sceptical about direct relationship between accounts and reality, assuming our experience is mediated through culturally shared concepts. A critical realist constructionist variant has also been differentiated, emphasising the importance of locating what is said in a broader cultural, historical and social context and taking an ontologically realist but epistemologically relativist position (Harper, 2012). The literature indicates that distinguishing between distinct epistemological positions can be difficult due to use of different terms; such positions may be best viewed on a continuum therefore.

This study took a position that fits with Harper's (2012) description of social construction although can also be viewed as overlapping with Madill *et al*.'s (2000) contextualist and radical constructionist positions. For ease of reading this will be referred to as social constructionist and what is meant by this in relation to the current study is now described. The study focused on the construction of knowledge and was sceptical of universal knowledge claims held by realists (Harper, 2012). Reports and descriptions of experiences were not seen as a window into people's thoughts and feelings; rather these accounts were viewed as serving a range of functions both interpersonal and societal (Harper, 2012). Social construction is most associated with research methods which focus on use of language e.g. discourse analysis (Harper, 2012). In line with the FDA approach taken, reality and identity were viewed as constructed and maintained through systems of meaning e.g. language and social practices (Georgaca & Avdi, 2012). From this perspective 'truths' of reality were not sought, rather the aim was to offer an interpretation or version seen as inevitably partial and it was assumed that the data could be interpreted in multiple ways, and it was not the intention to search for a singular truth (Taylor, 2001). Participants' accounts were seen to be co-constructed in the interview, and used in a functional and productive way in order to position the

subject, construct particular phenomena, and subsequently open or close opportunities for action and implicate subjectivity. Rather than considering participant's accounts as representations of a particular object; these representations were understood as constructing such objects e.g. concepts of formulation and collaboration. Furthermore, participants' discourses are viewed as context-dependent (Gilbert & Mulkay, 1984) and factors which may influence the production of knowledge from this perspective include: participants' and researchers' own constructions and cultural meaning systems (Pidgeon & Henwood, 1997).

Reflexivity

From a discourse analytic perspective, neutrality of the researcher is considered impossible because the researcher and research cannot be meaningfully separated (Taylor, 2001). Reflexivity: consideration of the way the researcher interacts with the world and the identity of the researcher, is viewed as important for discourse analytic research and particularly interview studies (Taylor, 2001). Identity of the researcher influences the selection of the topic or research area, and can influence the interview and responses of the participant due to many factors including age, position, power differences, perceived similarities and differences (Taylor, 2001). Furthermore the specific questions asked and manner of the interviewer may also invite different kinds of talk as well as influencing the interpretation and analysis (Taylor, 2001). From this position, it is important for the researcher to reflect and report upon their personal context and assumptions as these are acknowledged as inherent to conclusions drawn and analysis constructed. The first author (principal researcher and interviewer) presents this reflection in the first person below.

I am a 28 year old female trainee clinical psychologist. Participants included clinical psychologists whom I had encountered previously during the training programme when they have taken on roles of teachers, tutors and assessors. These prior relationships with some participants in previous contexts may have influenced the accounts constructed in the interview. The difference in status between a trainee and qualified Clinical Psychologist even without the additional complexity of tutor and student roles are considered to have potentially

influenced accounts constructed. For example I may have felt less able to challenge or probe further with questions due to the constructed power imbalance and perception of myself as 'only a trainee' and qualified clinical psychologists as more powerful and knowledgeable. Furthermore, some participants may have attempted to create more socially desirable accounts and been less willing to critique current professional practices in order to model constructions of 'good practice' to a trainee, and to maintain my representations of them as a knowledgeable and competent practitioner. Also particular accounts may have also been constructed with the perception that these may 'assist' me with my research. Conversely, this trainee to qualified relationship may have led to participants being more able to criticise their own practice or be open about practices due to perceptions that I was in a less powerful and knowledgeable position compared to if interviewed by another qualified psychologist for example.

As a trainee clinical psychologist with experience of working within a CBT framework, developing CBT formulations and working with people experiencing psychosis, I was drawn to research in this area. I hold the notion of collaborative working as important in my practice and seek to work collaboratively when formulating with clients. I have also reflected on challenges faced with this approach such as deciding when to share hypotheses or ideas and deciding whether such hypotheses may be helpful or a hindrance to clients, as well as sometimes finding it helpful to spend time outside of sessions reflecting and formulating but being aware that this seems less collaborative than doing this in session with clients. This has left me with some confusion about collaboration, what it means and how it can really be put into practice within a client – professional relationship.

Participants

Within qualitative research, large sample sizes are not needed to generate rich data sets as an individual person can generate hundreds or thousands of concepts (Starks & Brown Trinidad, 2007). It has been suggested that the exact number of participants needed depends on the goals and purpose of the study, the analytic object and data source (Starks & Brown Trinidad, 2007). Twelve

participants were recruited for the study, consistent with Georgaca and Avdi's (2012) recommendation that between 8 and 20 interviews are appropriate for a discourse analysis study. This is also consistent with other published examples of discourse analysis research concerned with mental health professionals accounts (e.g. Harper, 1995). Only one other discourse analysis study could be found which focused on CBT for psychosis (clients' accounts of) and this had a sample size of 5 (Messari & Hallam, 2003).

Eligibility criteria for inclusion in the study stipulated that participants must:

1) Be a clinical psychologist registered with the HCPC
2) Be employed by one of the three participating NHS trusts
3) Use CBT with people experiencing psychosis
4) Be willing to engage in at least one interview that would be audio recorded
5) Consent to take part in the study

Forty three participants were invited to take part and 12 of these met eligibility criteria and were willing and able to take part. The recruitment process is demonstrated in ***figure B***. Given the social constructionist perspective adopted, it was deemed important to situate the participants within their broader contexts and to ensure that this aspect of the research is as transparent as possible. Therefore participant characteristics from the self-reported demographic information sheet (*see Appendix H*) are presented in ***table 4.***

Figure B. ***Recruitment process***

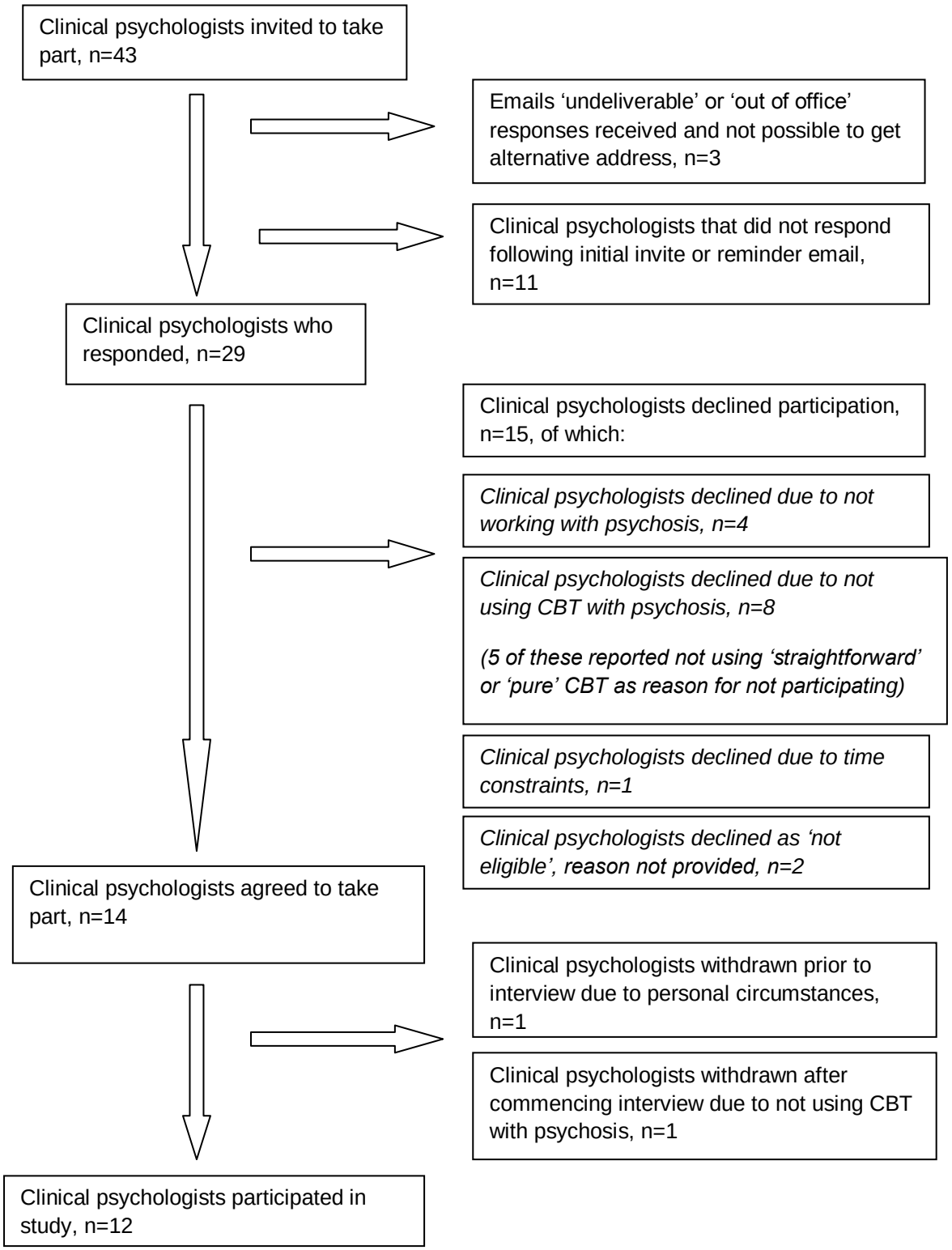

Table 4. ***Participant Characteristics***

Nature of service worked in	Inpatient rehabilitation n=4 Early intervention in psychosis n=3 Community mental health n=5 Secure n=1 Community/inpatient forensic n=2 Acute/crisis n=2 Assertive outreach n=3 No. of services worked across, range 1-5 No. of participants working across 2 or more services, n=5
Length of time worked in service	Range: 3 months – 18 years (M = 7, SD = 5.5)
Age range of clients seen in service	Range: 14 – no upper age limit
Approximate proportion of clients in service with psychosis	Range: <5% - 100% (M = 58%, SD = 34%)
Approximate proportion of participant's work conducted from broadly CBT perspective	Range: 30% - 100% (M = 64%, SD = 22%) *(1 participant did not give a percentage; reported only integrating aspects of CBT but never using as primary model)*
Years qualified as clinical psychologist	Range: 2 – 23 years (M = 10.5 years, SD = 6.8)
Further CBT training/qualifications completed?	Participants reporting further CBT training n=9 *(including: DBT, ACT, CBT-P, CBT-PD, CBT for anger, complex formulation CBT)* Participants accredited with BABCP n=1 Participants completed CBT-P training n = 3
Further formulation training completed?	Participants completed further formulation specific training n=8

Ethical considerations

The study was conducted in accordance with codes of ethical practice which have origins in the Declaration of Helsinki 1964 (World Medical Association, 2008), including the 'Research Governance Framework for Health and Social Care' (Department of Health, 2005) and the British Psychological Society (BPS, 2011) 'Code of Human Research Ethics' guidelines. In addition, the HCPC 'Standards of Conduct, Performance and Ethics' (2008) were adhered to. The study was not thought to cause any harm to participants; several participants commented on valuing the opportunity to consider their formulation practice in so much detail, reporting that some of the questions probed them to think about specific aspects of practice and reasons for making decisions that usually happened in a natural and automatic way, indicating this facilitated a new perspective.

Participants were able to withdraw their data from the study without giving reason, for up to 72 hours excluding weekends. Participants were made aware of this in the information sheet (*see Appendix B)* and consent form (*see Appendix G*). No participant requested for their data to be withdrawn. To ensure anonymity, participants were given a unique identification number and then a pseudonym. Participants' real names were not used during the interview so the audio recording was anonymous. The professional transcriber signed a confidentiality agreement (See *Appendix L*) binding them by the terms of the agreement as well as with the Data Protection Act (1998). In accordance with University of Lincoln guidelines and the Data Protection Act (1998) all identifiable and anonymised data will be stored in a locked filing cabinet at the University of Lincoln, held for seven years and then destroyed. Clinical psychologists and trainee clinical psychologists were consulted with to gain perspectives on the proposed study and to check the clarity of participant information sheets and consent forms.

Procedure

Within discourse analysis, groups can be sampled according to whether they participate within a given discourse; this can highlight ways in which people

appeal to external discourses and recognize their influence on the discourse under study (Starks & Brown Trinidad, 2007). A purposive sampling technique was utilised for recruitment; this involved selecting cases which would be able to offer rich accounts and constructions of issues central to the research (Patton, 1990). Therefore clinical psychologists who reported using cognitive-behavioural formulations with people experiencing psychosis and would be able to provide accounts of this process were selected for recruitment. Clinical psychologists were recruited from a range of settings and services and with varied experiences, therapeutic orientations and training experience. It was hoped this would facilitate variety in participant accounts and constructions of formulation processes and collaboration as variety is seen as interesting within a discourse analysis approach.

Potential participants received information sheets along with their letter of invitation (*see Appendix A*). Reminders were sent out at least one month after the initial invitation to those who had not responded. All interviews were conducted at least 24 hours (although usually weeks or months) after receiving this, and were conducted at the participant's place of work, in a private room. All participants were offered the chance to ask questions prior to completing the consent form and then demographic information sheet (*see Appendix H*). Participants were asked if they wish to receive information about the findings of the study at its completion and indicated this on the consent form. It was explained that this would require the investigator to retain their contact details. All participants had the capacity to consent and participants were not compensated for their time.

Interviews

A range of data collection methods can be used for a discourse analysis study including observations, interviews and a close reading of texts (Starks & Brown Trinidad, 2007). The objective of interview methods in discourse analysis studies is to capture participant's language including references and appeals to particular discourses (Starks & Brown Trinidad, 2007) as well as considering functions of language use within both the local interactional context and wider contexts.

The use of interviews in discourse studies has been a debated issue. Some critics of interview use suggest that these are highly variable and context-dependent whilst advocating that it is possible to overcome such limitations with direct observation of social action as it occurs (Gilbert & Mulkay, 1984). It has been suggested however that direct observation does not free the observer from reliance on variable discourses of participants or the context-dependent nature of the specific situation (Gilbert & Mulkay, 1984). Furthermore, since discourse analysis approaches treat respondents as active participants who create, rather than report on reality, the issue of 'bias' is seen as inevitable but also theoretically interesting (Speer, 2002). Speer (2002) further states that "attempts to control bias may not only be futile, but may stifle the very features of interaction that are theoretically interesting" (p. 512). Furthermore interviews enable the researcher to question participants on the same topics and allow for active intervention (Potter & Wetherell, 1987). Within this study, interviews were seen as a useful method of eliciting clinical psychologist's accounts of formulation practices in CBT for psychosis and for eliciting talk about collaboration and collaborative actions. Interviews offered the opportunity to influence the topic of talk and to enable this to be focused on issues pertinent to the research question. Both the interviewer and participant are viewed as active and responsible for co-constructing the accounts reported in the interviews. However it is also acknowledged that 'naturally occurring' talk, such as recorded data from therapy sessions themselves, particularly those focusing on developing a formulation within CBT for psychosis would offer alternative constructions and accounts which may also be of interest for furthering the research in this field.

Face to face interviews enable the researcher to build a rapport with participants which can be instrumental in gaining trust and cooperation (Rosnow & Rosenthal, 2002). In addition, they provide the researcher with the flexibility to change the wording of questions, and prompt for further detail as necessary, useful for the exploratory nature of this study. There are some limitations of face to face interviews, including being more time consuming than other methods, and socially desirable responding may occur due to the lack of a feeling of anonymity that other methods e.g. questionnaires, provide (Rosnow &

Rosenthal, 2002). However, as the approach taken views language itself as the topic of study rather than a resource to understand some underlying reality, these ways of responding are of interest rather than being seen as a 'bias'. Furthermore formulation within therapy is something widely discussed by clinical psychologists so it was felt that participants would be likely to feel comfortable discussing this topic. This method also enables the schedule of questions to be altered between participants depending on the initial analysis conducted and emerging patterns of talk, and to refine the schedule to facilitate variety in accounts and to probe further about particular constructions and discourses accounted for in the interviews. This approach of adjusting the interview schedule draws on theoretical sampling techniques advocated in grounded theory (e.g. Corbin & Strauss, 2008). In addition, interview methods are suitable for use within a range of epistemological perspectives, including social constructionist (Frith & Gleeson, 2012).

The initial interview schedule was developed through supervision, a provisional review of the literature, and consideration of areas which may be fruitful in eliciting talk about collaboration and formulation in CBT for psychosis. The schedule was amended to continue to elicit a variety of accounts and constructions about the topic and particular patterns of talk identified (see *Appendix J* for example*)*. The interview schedule began with broad and mainly open questions to facilitate participants to report and account for the process of formulation and as particular constructions were noticed or accounts of particular interest were constructed, the schedule was amended to further elicit a variety of reports.

Transcription of interviews

Five interviews were transcribed by the chief investigator, and seven interviews were professionally transcribed. All interviews were transcribed verbatim. Potter (2003) suggests that the process of listening carefully to material generated during this process is often when analytical insights are first developed; it was deemed helpful to the research for the chief investigator to complete the initial transcriptions and become immersed in the data. However, due to practicalities and time constraints it was necessary to utilise a professional transcriber for the

remaining interviews. The researcher read each transcript carefully while listening to the audio recordings to check accuracy of transcriptions and to facilitate the researcher to still become somewhat immersed in, and familiar with the data.

Transcriptions can include varying levels of detail, from just including words spoken, to including a range of utterances and symbols to represent the tone and style of speech. The level of detail selected depends on the theory and aims of the research project (Taylor, 2001). The best known set of transcription symbols comes from Jefferson, and a selection of these symbols may be used to form a lighter form of transcription. Elaborate notation of details which are not relevant to the analysis can make the transcript difficult to read; a transcript therefore needs to construct a version of the interaction which is to be analysed (Taylor, 2001). Therefore a light version of the Jeffersonian transcription system was used (See *Appendix I*, Woofitt, 2001) as this allows for adaption to the amount of detail required (Kitzinger & Frith, 2001).

Analysis

Following transcription, several close readings of the data were carried out; an initial coding was then performed which involved selecting extracts relevant to the research question (Georgaca & Avdi, 2012). Coding data involves organising and categorising to identify patterns in language use, building up and referring back to assumptions made about the nature of language, society and interaction (Taylor, 2001). From this initial coding, the researcher became immersed in the texts and patterns and functions of talk began to be constructed. Analysis of discourse is an iterative process and involves going over the data again and again (Taylor, 2001). Willig's (2008) six stages of analysis were used as a guideline for analysis; this is outlined below:

1. Discursive Constructions

This stage of analysis considers how discursive objects are constructed e.g. how clinical psychologists construct and talk about concepts of 'formulation' and 'collaboration' both explicitly and implicitly.

2. Discourses

This involves a focus on differences between constructions of these discursive objects. Different constructions of ‘collaboration’ in psychological formulation, such as of this as empowering, involving openness and transparency, and as a contrast to medical approaches of diagnosis and treatment, can then be linked with wider discourses such as the ‘removal of power and control in psychiatric inpatient settings’.

3. Action Orientation

This stage involves a closer examination of the discursive contexts in which these constructions are being used. Consideration is given to what is gained from constructing this object this way and what is its function, giving a clearer understanding of what the various constructions are capable of achieving within the text.

4. Positionings

The particular constructions of discursive objects and the wider discourses on which these draw are used to help us consider the subject positions which this offers. Discourses are viewed as constructing subjects as well as objects. Such positions offer discursive locations from which to speak and act.

5. Practice

This stage is concerned with the relationship between discourse and practice. Subject positions and discursive constructions are viewed as opening up and closing down opportunities for action. Certain practices therefore become legitimate within certain discourses.

6. Subjectivity

The final stage of analysis considers the link between discourse and subjectivity; discourses and subject positions are seen to construct social and psychological realities.

It should be noted however that these stages of analysis were not used in a restrictive fashion but were used as guidelines, offering ways of looking at and understanding the data. The concept of subjectivity has been contentious within discourse analysis and discursive psychology approaches, for example Edwards and Potter (1992) deny the notion of subjectivity and other cognitive constructs about the internal world as previously discussed. The notion of subjectivity also requires more speculation and so this study drew primarily of stages one to five of Willig's (2008) guidelines.

Quality

There are difficulties judging quality or validity in qualitative research as qualitative researchers often take the perspective that different people have different yet equally valid perspectives on 'reality' shaped by culture, context and activities (Yardley, 2008). Furthermore, psychology has historically been dominated by quantitative methods so there has been a tendency for psychologists to assume criteria for validity in quantitative methods, such as objectivity, reliability and generalisability, are also relevant in qualitative methods (Yardley, 2008). Such positivist criteria are not meaningfully applicable to qualitative research however (Willig, 2008) and are particularly inappropriate for research taking a social constructionist position (Madill *et al.,* 2000). Madill *et al.* (2000) emphasise the importance of taking into account epistemological position when considering quality criteria and report that researchers working within a contextualist or constructionist epistemology are more likely to reject a straightforward transference of criteria such as objectivity and reliability into their work as it is no longer assumed that there is one reality that can be uncovered through utilising the correct methodology. From the social constructionist position taken by the research, it is viewed that the research and findings are constructed between the researcher and participants and that the findings are inevitably one of many possible constructions. However as Madill *et al.* (2000) point out, it is still important that qualitative research is open to scrutiny and that credibility of findings is based on more than just the researcher's authority. Several quality guidelines for qualitative research are available and were considered for the study. For example, Elliot, Fischer and

Rennie's (1999) guidelines were contemplated. It was viewed however that some of the criteria advocated, such as the notion of credibility checks, by referring to other's interpretations or using various methods to gain different perspectives on the subject, were inappropriate for a social constructionist study which views the analysis as inevitably co-constructed, so issues of 'bias' becomes meaningless. It was decided that the guidelines offered by Madill *et al.* (2000) for constructionist research would be most useful and appropriate and were used to inform this study.

Madill *et al.* (2000) propose that internal coherence, deviant case analysis, and reader evaluation are appropriate quality criteria within a constructionist context. Internal coherence refers to the evaluation of the extent to which the analysis does not contain major contradictions and 'hangs together'. The authors recommend that researchers seek out material to challenge their developing theory so to explain exceptions to the rule as well as typical examples. Deviant case analysis therefore delimits the context of its applicability. Reader evaluation considers whether the study contributes understanding and insights of the phenomena. These guidelines were borne in mind throughout analysis by the researchers and the reader is also invited to consider these criteria in order to evaluate the quality of this study.

EXTENDED ANALYSIS AND DISCUSSION

This extended analysis and discussion is organised thematically, primarily around dilemmas that participants themselves oriented to. Briefly these are: clients' rights to hold own views regarding the formulation, how to resolve disagreements, and how open to be with clients. The analysis moves on to demonstrate further constructions of collaboration; particularly its subjectification. The section concludes with analysis focusing on the research process itself and how participants positioned themselves within interviews.

Collaboration: a matter of rights?

The following two extracts demonstrate contrasting ways of constructing of differences in opinion between client and psychologist within the formulation process. The first account builds the argument that clients have a right to their own perspective and that this should be accepted by the psychologist.

Excerpt 6 (Jennifer)

I: OK thank you and how would you say I guess this has already come
up in dribs and drabs throughout (.) but how would you say you promote
collaboration when you're developing the CBT formulation
P: I think it's yeh it is it's like I've said already it's about working out what
someone can tolerate (.) not being pushy about your own agenda erm
(.) and I think erm not having to force people to see the links that I want
them to see (.) so it is it is totally about working out where the person is
at, what they can manage what would be helpful for them what do
they want to focus on not everybody wants to talk about whether or
not there's you know what's happened in their family whether there's
been a long history of abuse what that was all about some people
want to say (.) this is all a genetic thing (.) for me (.) it shouldn't matter
you know I'm (.) people are entitled to believe what they want to believe
and my role is then about saying OK how (.) why are you in this system
then (.) what is it is it about that it's too distressing that it's interfering
with your quality of life and how do we work together on that (.) because

17. otherwise (.) I think it becomes my agenda I am due to see this from a
18. psychological perspective that is from your history and your childhood
19. you know (**I:** yeh) that's about me if the person doesn't want to go
20. there then that's their right

In this extract collaboration is described in two ways. First as determining client needs and limits and adhering to these, and second as accepting perspectives that differ from the psychologist's own. The term *"working out"* is used on lines 4 and 7 to describe the process of determining what the client can *"tolerate"*, "*where the person is at", "what they can manage"* and *"what would be helpful for them"* (lines 7-8). This positions Jennifer as responsible for determining these needs and limits, rather than as the client explicitly communicating these. The word "*totally"* is used on line 7 to emphasise the importance of tailoring the formulation to the individual; this can be seen as a way of positioning herself as led by the client. The words *"tolerate"* and *"manage"* (lines 5, 8) depicts that as well as potentially helpful, formulation can also be challenging for clients.

Collaboration is also constructed as involving acceptance of client beliefs even when these differ from the psychologist's. Jennifer states *"people are entitled to believe what they want to believe"* (line 13); the word entitled here along with references to clients' *"right[s]"* (line 20) draw on a discourse of rights and constructs beliefs and choices as an entitlement. On line 12 Jennifer argues that difference in opinion between the client and practitioner *"shouldn't matter"*, constructing that an agreed understanding is not necessary. This is preceded by the words "*for me"*; this can be seen as a way of positioning herself within the interview as accepting of different beliefs. Jennifer continues to develop this argument by stating that personal biases, for example viewing difficulties "*from a psychological perspective"* (line 18) can be remediated against by *"not being pushy"* about the agenda and *"not having to force people to see the links"* (line 5-6) that she suggests.

However the account constructs that personal views and differences may play more of a role than the participant explicitly argues for. For example on line 12 the participant reports *"some people want to say this is all a genetic thing"*. Use of the word "thing" here discredits the biological account. This follows reports on

lines 9-11 that not everybody *"wants to talk"* about what has happened "*in their family"* or whether there has been "*a long history of abuse"*; arguing that labelling experiences as genetic may alleviate unwanted conversations or consideration of difficult past experiences. This suggests the client's beliefs are serving a function and places more value on the *"psychological perspective"* taken by the participant. Alternative constructions, for example that issues of abuse or family history may not be of importance or relevance to the client could be more challenging to clinical psychology practices.

Jennifer unpicks her construction of collaboration and depicts a pragmatic self to manage differences in understandings; issues of 'truth' no longer matter and it is what is helpful instead that is sought. For example, she describes asking the client questions to determine what is distressing and what impacts on their quality of life (lines 14-16). This position may reduce discomfort and conflict around holding opposing views to the client; saving collaboration and allowing for different perspectives to be held whilst still working with the client to alleviate distress.

This construction of the importance of accepting client beliefs as a right offers power to the client, and contrasts with subsequent extracts 7 and 8. Similar to excerpts in the journal article, although collaboration is described as a simple process it appears more complex. For example despite claiming to accept the client's perspective, language used places more value on the participant's psychological perspective which seems to reduce opportunities to be completely accepting of other views. As in previous extracts, the client is positioned as requiring protection from the psychologist who is responsible for determining limits and needs, placing them in an expert position.

Excerpt 7 (Gregg)

1. **P:** I can also think of bad experiences yeh where I've I've written reports
2. and people have got <u>so</u> pissed off and been <u>so</u> angry and I've known
3. that my feeling is my formulation is correct but (.) it's just too
4. challenging for them (**I:** Umm) you know especially when you've got a
5. lot of people with forensic histories as well (.) so I think you're going to

6. have to take <u>that</u> into account you're trying to make sense of their
7. offending behaviour and stuff people can get <u>really</u> pissed off about that
8. and really upset WHAT DO YOU MEAN IT'S NOT JUST TO DO WITH
9. ME HAVING AN ILLNESS (.) WHAT YOU SAYING I'VE GOT SOME
10. RESPONSIBILITY FOR THIS AS WELL (.) WHAT YOU SAYING I'VE
11. HAD SOME CHOICES (.) yeh (.) that can be challenging for people

The key features of talk here are the construction of formulation as 'shared with' the client and justifications for conflict resulting from sharing the formulation. Gregg states "*I've written reports*" (line 1) and uses the phrase *"my formulation"* (line 3). Using words such as "I" and "my" here construct the formulation as belonging to the psychologist, and that this has been developed and then presented to the client. The question posed by the researcher to elicit this account asked about a time "*when you've shared a formulation"*. This also constructs the formulation as pre-produced and may have influenced the subsequent account. This construction of formulation as 'shared with' the client, rather than 'developed with' seems to occur more frequently in accounts and positions the psychologist as the expert in the relationship, with more power and responsibility. This seems at odds with the notion of collaboration.

An extreme case example is utilised to portray challenges faced when sharing formulations with a client as invited by the interview question. Gregg describes a client becoming "*pissed off"* and *"angry"* (line 2) due to the formulation. The word *"so"* is used to prefix these terms and emphasise the emotive response. This could be seen as a discursive strategy constructing the client's response as out of proportion, weakening the credibility of this response in order to justify the psychologist's formulation. Gregg reports that he "*feel[s]*" his formulation is *"correct"* (line 3) before justifying the client's angry response by describing this as "*too challenging"* (lines 4, 11). Using the word challenging positions the client as unable to cope with the *"correct"* formulation offered rather than alternatively constructing the formulation as problematic.

Gregg seems to unpick possible reasons for the client's angry response and attributes this to the issues of "*responsibility"* and "*choices"* reported to be inherent within the formulation (lines 9-10). A discourse of offending behaviour

is also drawn upon as the speaker describes the need to take *"into account" "forensic histories"* and *"offending behaviour"* (lines 5-7). Categorising the client as an offender may further serve to weaken the credibility of the client's emotive response and justify the formulation. Furthermore, Gregg draws on a medical discourse of mental illness and positions the construct of illness as opposing ideas of responsibility and choice. The use of the word *"just"* on line 8 could be viewed as a discursive strategy to dismiss this medical construction.

These discursive strategies may serve to manage issues of personal accountability (Horton-Salway, 2001) and may reduce discomfort associated with alternative constructions i.e. that the formulation is incorrect or even harmful due to the distress caused to the client. Such an account could threaten the psychologist's position as helper and also the practice of formulation and clinical psychology. By using rhetorical strategies to justify the client's distress and weaken alternative medical discourses the participant serves to maintain or promote power in the institution of clinical psychology. This account contrasts with the previous which constructed that clients have a right to different beliefs; here client differences are instead constructed as incorrect and are discredited.

Excerpt 8 (Gregg)

I: OK what steps do you take then to try and erm ensure that people are
having a good experience of formulation rather than a negative
experience (.) I guess it's not always that clear cut but
P: I guess by trying to er ((laughing)) sometimes tiptoe around and kind of
asking is it bullshit but yeh sometimes kinda er we'll just pay a bit more
attention to THESE GOOD BITS THAT YOU WANNA HEAR and we'll
just these bits here that are a bit too challenging for you we'll just
kinda talk a little bit about it but let's move on quickly yeh I guess kind
of using your therapeutic skills to just try and er ((laughing)) deal with
it erm yeh I don't know if I can say anything more profound than that
(.) just being a bit light on your feet not kind of clomping in there
trying not to you know well what is the ultimate purpose it's not to try
and hurt the person or to make them feel (.) down and disheartened
and stuff hopefully the formulation should have some pragmatic value

15. and help them (.) so yeh just trying to be a bit diplomatic at times

The salient feature of talk here is the construction of being *"diplomatic"* (line 15) as a way ensuring a good experience of formulation. Gregg reports "*tiptoe[ing] around"* (line 4) when sharing the formulation, suggesting he would pay "*more attention to these good bits"* and only talk *"a little bit"* about more *"challenging"* parts before "*mov[ing] on quickly"* (lines 5-8). This outlines the formulation as something which can be negotiated using diplomacy; a new construction of actions taken to manage difficulties in developing a shared understanding. This account reduces opportunities to re-develop the formulation incorporating the client's views and again contrasts with the construction of clients having a right to their own understanding. This account positions the participant as an expert and the client as lacking power, unable to influence the formulation and being unknowingly coaxed into taking this perspective by the psychologist emphasising certain aspects and diminishing others; a construction appearing at odds with the notion of collaboration. Gregg draws on a therapeutic discourse, accounting for these diplomatic tactics as *"therapeutic skills"* (line 9), drawing the listeners attention to the skills of the professional here. Such tactics are further justified by referring to a moral and pragmatic discourse; reporting that the aim of the formulation is "*not to try and hurt the person or to make them feel down"* but instead to have "*some pragmatic value"* (lines 13-14). This positions the participant as having a duty to protect the participant from potentially hurtful aspects of the formulation.

These three extracts illustrate contrasting constructions of collaborative formulation deployed by clinical psychologists; as accepting clients' rights to own views and understandings, as well as constructing client perspectives as lacking credibility and using diplomacy to manage differences. The first construction positions the psychologist and client as equals; both bringing different but equally credible knowledge to the formulation process. The second alternatively positions the psychologist as more powerful within this process, and as having expert knowledge, drawing on wider discourses of professionals as experts within mental health (discussed by Rogers & Pilgrim, 2010).

Developing a shared understanding or agreeing to disagree?

The following three excerpts highlight contrasting constructions of collaboration as developing a shared and agreed upon formulation but also as agreeing to disagree.

Excerpt 9 (Matthew)

1. **I:** Yeh ok (.) and what would you say makes a <u>good</u> CBT formulation for
2. people with psychosis
3. **P:** One that's (.) erm (.) collaborative and I guess doesn't erm (.) one
4. that's kind of shared and doesn't kind of collide too much with the
5. person with psychosis' erm experiences (I: umm) so you're not going
6. in there and (.) erm rubbishing their kind of theories or there kind of
7. prior kind of formulations (**I:** yeh) so something that comes in at a level
8. that the client can kind of (.) hear and kind of understand
9. **I:** Yeh so it's about that collaboration the <u>shared</u> understanding that's
10. important
11. **P:** Think so yeh
12. **I:** And would you say that you always explicitly use formulation with
13. Every client
14. **P:** I wouldn't say so no (I: umm) erm sometimes I will with clients be
15. quite explicit and get the formulation down on a piece of paper (I:
16. umm) (.) but for other clients the kind of formulation (.) is kind of tied in
17. with as we're kind of assessing (I: yeh) and kind of discussing (I: yeh)
18. and I suppose kind of for me kind of sometimes kind of the most helpful
19. types of therapies that I deliver with clients are the ones that might
20. appear to the client as (.) as a (.) as a kind of a discussion (**I:** umm), a
21. helpful kind of discussion

Matthew describes a *"good"* formulation (line 1) as invited by the question, as one which is *"collaborative", "shared"* (lines 3-4) and accessible i.e. the client can *"hear"* and *"understand"* it (line 8). This constructs collaborative formulation as the ideal. When arguing what does not constitute a good formulation on lines 5-7, the phrase *"you're not... rubbishing their kind of theories"* or *"formulations"* conversely constructs this non-collaborative practice as bad formulation. Furthermore, saying *"you're not",* as well as using the pejorative term

"rubbishing" distances Matthew from this practice and can be seen as a way of positioning himself, at least within the interview, as a collaborator.

The second half of the extract (lines 16-21) describes formulation as implicit rather than explicit, for example as *"tied in"* with assessment and as something that "*might appear to the client as... a discussion".* This portrays that formulation may happen without the client knowing about it, calling into question the possibility of previously emphasised collaboration within this process. As in previous extracts, Matthew draws on a pragmatic discourse to justify this, claiming that this is "*most helpful"* (line 18). Using the words *"for me"* to precede this may be a discursive strategy which serves to make the claims irrefutable; it cannot be disputed that for the participant this may be the case and therefore persuades the listener to hold this account as factual.

The differing constructions presented here can be seen as having different consequences for the balance of power between client and participant. Positioning himself as a collaborator who develops a shared understanding and is careful not to discredit client theories empowers the client. In the same account the psychologist is also positioned as an expert however, able to make judgements and interpretations about the client's needs without sharing this process explicitly, this promotes the power of the psychologist.

Excerpt 10 (Carol)

P: But sometimes (.) I guess it could be frustrating I'm thinking of one lady in particular who's had a horrendous trauma history erm (.) and she experiences a lot of things that could be viewed from a PTSD (.) erm framework so lots of erm (.) erm re-experiencing so lots of physical sen tactile physical sensations that she attributes to spirits (**I**: Umm) so we've we've negotiated erm, you know I don't say well I don't believe it's spirits but I've I've introduced there could be another way of formulating and understanding (**I**: Umm) kind of lots of other people have had similar experiences to you may experience similar things (**I**: umm) and we might suggest what we know from trauma and psychosis and the link between the two is that [pause] what it could be memories

that are coming back and kind of aspects of that and erm (.) but then you know it might be but it's spirits, it's spirits (.) OK lets, so how can we help you feel safer when these spirits come so you have to (.) you've got that (.) well I'm thinking it's trauma and that kind of way of understanding the but the (.) say it's a a balance I suppose because it could if I didn't step into her frame of reference it would be frustrated and sometimes you do that checking out s- (.) you know I think you're feeling quite frustrated I'm wondering if you're thinking that I'm thinking I'm right and you're wrong I just want to clarify that's not what I'm saying you know (.) can we (.) can we agree that there could be other ways of viewing this as well as that its spirits there

The word *"negotiated"* on line 6 is used to describe the formulation development; this implies two different perspectives are held over which stakeholders barter to come to an agreement. The word *"balance"* on line 16 reiterates this construction of a struggle to find middle ground between two opposing viewpoints. Furthermore Carol reports taking actions to promote alternative ways for the client understand their experiences: *"I've introduced there could be another way of formulating and understanding"* (lines 7-8) and later *"can we agree that there could be other ways of viewing this as well as that its spirits"* (lines 21-22). The emphasis on the words *"as well"* serve to distance Carol from an invalidating or opposing position and instead position her as accepting of multiple perspectives, similar to excerpt 6. Furthermore this constructs collaboration as agreeing to disagree with the client and accepting differences, contrasting with the previous excerpt which emphasised a shared understanding as central to collaboration.

Carol is careful not to explicitly report holding a different view to the client, and appears unwilling to disclose her own opinion, for example stating *"I don't say well I don't believe it's spirits*" (lines 6-7) and *"I'm wondering if you're thinking that I'm thinking I'm right and you're wrong, I just want to clarify that's not what I'm saying"* (lines 19-21). Furthermore Carol uses tentative language such as modal auxiliaries *"could"* and *"might"* (lines 3, 7, 10-11, 13) when discussing possible formulations, to portray these as one of multiple possibilities. Within the

interview this could be seen as a way of Carol positioning herself as accepting of other views.

Despite this apparent reluctance to disclose holding contrasting views to the client; this account clearly portrays differences. For example, Carol describes the experiences within a psychological discourse using statements such as *"I'm thinking its trauma"* (line 15) and that it *"could be viewed from a PTSD framework"* (line 3) whereas the client is described to draw on a spiritual discourse: *"she attributes to spirits"* (line 5). Despite explicitly stating the importance of *"step[ping] into her frame of reference"* (line 17), language used does not suggest Carol is actually willing to consider the client's own formulation. Rhetorical strategies such as use of consensus (Potter & Wetherell, 1987) are used to add weight to the participant's understanding as they report *"lots of other people have had similar experiences to you, may experience similar things"* (lines 8-9) and again on line 10 as the participant states *"what we know"* to persuade the listener that the client's experiences can be accounted for due to trauma. Framing the client's experience in terms of a diagnostic category: *"PTSD"* draws on a scientific discourse: positioning the participant as a knowledgeable expert and further adding weight to her formulation.

Carol justifies herself on the basis of pragmatism to manage difficulties coming to a shared agreement with the client, reporting trying to help the client *"feel safer when these spirits come"* (line 14). As in previous excerpts, this account demonstrates clinical psychologists' attempts to position themselves as accepting of different perspectives and as a collaborator, whilst detailed analysis of talk indicates that issues of collaboration are much more complex and discursive strategies used often place more value on the psychologist's perspective. Contrasting with previous excerpts is the construction of collaborative formulation as a process of negotiation between two parties.

Excerpt 11 (Martin)

1. **P:** I suppose it would be to see whether somebody could erm begin to
2. make more distinctions between thoughts and feelings say and
3. thoughts and behaviours but they're sort of more clearly differentiated

4. and (.) that might just take just might mean that your early phase of sort
5. of developing a formulation might just go on a lot longer (.) and then I
6. suppose it's about well how long have you got (.) how long has the client
7. got before you get to the point where you say oh actually we're not
8. really getting anywhere (.) Erm which obviously does happen so (.) I'll
9. I suppose I'll kind of say well you just (.) you keep going back until you
10. get to a point where you can (.) make the model work for that person's
11. experience (.) But that I guess that, you know there's always going to
12. be a limit to that (.) It's not always going to be possible (.) I'm not sure
13. then what the alternative is erm might be just it might be more about
14. erm working to think about what that person might find containing even
15. if that person can't do it collaboratively and working in more of a
16. consultative way with other people to say (.) well you know it may be
17. that they seem to find erm because I think some people find the medical
18. model quite containing and they prefer to stick with that ((laugh)) rather
19. than sort of taking any kind of erm sense that they can personally
20. manage or kind of own what's happening to them they'd rather just
21. have it this is this weird thing that happens to me and if I take

medication that makes it betterIn this excerpt three key features of talk are noted. First Martin constructs *"mak[ing] the model work"* and actions taken to achieve this. On lines 1 and 2 he describes seeing whether the client could *"begin to make more distinctions between thoughts and feelings"* and "*keep[ing] going back"* (line 9) in order to make the model work. This constructs CBT formulation development as a layered process beginning with the client's ability to identify thoughts and feelings and moving towards more complex understandings. This constructs that collaboration cannot take place until there is a shared starting point in CBT, including a subjectivity of being able to tell thoughts and feelings apart. This fits with wider constructions in western society about the subjective self; with beliefs and thoughts within us which we can communicate through language (Rose, 1998). This account constructs the client as needing to change their understanding, with Martin as the facilitator and

teacher. As discussed by Overholser (2011) this position as teacher and educator within CBT appears at odds with one of equal collaborator.

Second, Martin constructs working non-collaboratively if the model cannot be made to work in a collaborative way, and uses discursive strategies to justify this. This account describes working towards what someone *"might find containing, even if that person can't do it collaboratively"* (lines 14-15). Here Martin's use of words ("*if that person can't*") constructs this difficulty as being due to the client therefore reducing his own agency and responsibility over this. On lines 15-16, *"working in more of a consultative way with other people"* is described as an alternative to collaborative formulation. This account outlines an approach of moving towards using consultation with others, and agreeing to disagree (similar to excerpt 10) when struggling to develop a shared formulation with the client. However unlike the previous extract, this approach is constructed here as distant from a position of collaboration.

Martin reports a time-limit to his attempts at developing a shared formulation, saying *"it's about well how long have you got?"* and then "*how long has the client got?"* (lines 6-7). The participant here uses a rhetorical question, known for their use as an effective persuasive device (Frank, 1990) providing functions including excusing (Brown & Levinson, 1978). This can be seen as a way of persuading the listener that there should be a time-limit to attempts at developing a shared formulation and serves to excuse the participant from ending such attempts. The participant does backtrack subsequently, stating on line 9 *"you just you keep going back"*. This indicates that the participant adopts two positions here, one of not giving up and another of accepting a shared formulation may not be possible or agreeing to disagree. Stating collaborative formulation is not always possible externalises such limits and positions the participant as having a lack of control or agency over these.

Third, language is used to discredit the client's medical construction of their experiences. Martin constructs the client's account as serving a function by saying on lines 17-18 "*I think some people find the medical model quite containing"*. Martin offers reasons for why this understanding may be containing, constructing that holding a medical understanding is an alternative

to taking responsibility (also seen in excerpt 6): "*taking any kind of erm, sense that they can personally manage or kind of own what's happening to them".* The use of the words *"I think"* (line 17) can be seen as a way of Martin positioning himself as open to alternatives and also makes the statement irrefutable. Describing this as *"containing"* argues that the client holds a stake in this construction, weakening the credibility of this account.

Despite all participants describing collaboration as important within formulation; constructions of collaboration varied from a shared and agreed formulation to accepting difference and agreeing to disagree. It seems that participants often constructed a shared and agreed formulation as the ideal, but when difficulties within this process began to be reported, agreeing to disagree and taking a pragmatic approach was then constructed as an acceptable alternative form of collaboration.

'Testing hypotheses' or 'proving them wrong'

A couple of participants drew on a principle central to CBT when discussing managing differences; namely collaborative empiricism. Even when discussing this central CBT technique participants deployed differing constructions, including 'testing out beliefs or disagreements as helpful and collaborative' but also confrontational and a way of 'proving the client wrong'.

Excerpt 12 (Martin)

1. **I:** And you said about the importance of developing the formulation
2. collaboratively, how would you ensure that it was developed
3. collaboratively?
4. **P:** Right ((cough)) well I think it's (.) it's partly it's partly a process of
5. continually checking out with the person you're trying to help (.) that
6. any ideas that you're offering, that the model itself kind of (.) makes
7. some sense to them (.) and that they that you have to gauge as well
8. and test out with them whether that that's a sort of (.) a you know (.) a
9. genuine agreement or whether it's some kind of compliance (**I:** umm)
10. which is not necessarily based on erm (.) recognition or agreement but

11. but maybe there for other reasons (.) I think that obviously clinical
12. experience and skills in terms of engagement and maintaining a
13. therapeutic alliance are key things there (**I:** yeh) Again they're not
14. specific to CBT (.) but I think if you're working from a CBT framework
15. then you're going to put a lot of emphasis on things being explicit
16. things being erm that you only move forward when you feel there really
17. is a shared understanding (.) you don't move forward on the basis of
18. what might be erm (.) a kind of erm (.) erm (.) outward agreement that
19. isn't based on a genuine you know recognition or agreement (.) that's
20. not to say that there can't be disagreements (.) but they become part of
21. the hypothesis testing process so if a client doesn't agree with you
22. about something then you could (.) if you think it's important then you
23. could say would you be willing to put that to the test you know could
24. we explore it experiment with it (.) or equally if there's something they
25. think's important that you think's probably a red herring I would
26. suggest the same but I think unless you do that you're unlikely just to
27. carry the client with you ((cough))

In this excerpt, Martin constructs collaboration as *"a process of continually checking out"* (line 5) ideas with the client to ensure that these *"make[s] some sense" (*lines 6-7). Collaboration is further described as a *"genuine"* agreement which is then differentiated from *"compliance"* on lines 9-11 and re-iterated on lines 17-19). It is reported that it is not possible to *"move forward"* (line 17) without this genuine agreement. This is similar to previous constructions of the importance of having a shared understanding and constructs this as fundamental to the CBT process. The words *"you're offering"* on line 6 construct that the psychologist has ideas that are then offered to the client to gain feedback. This positions Martin as an expert who is *"trying to help"* (line 5) the client by offering knowledge. This is further developed on line 27 in the statement *"you're unlikely just to carry the client with you"* (if there is not a shared understanding); this interesting choice of metaphor positions the psychologist as a helper rather than equal partner.

Despite the reported importance of a shared understanding, Martin also claims that different opinions are not problematic: *"that's not to say there can't be disagreements"* (line 20). This can be viewed as a way of Martin positioning himself within the interview as a collaborator but also as accepting of different perspectives. Martin talks about managing difficulties when "*a client doesn't agree"* by asking the client to "*put [it] to the test"* or conduct an *"experiment"* (lines 21-24). This contrasts with excerpt 10 in which Carol constructs 'agreeing to disagree'; here Martin conversely builds the argument for the importance of getting to a shared and agreed understanding by testing out disagreements, constructed here within descriptions of collaboration. Interestingly, Martin describes this process of *"hypothesis testing"* (line 21) for situations where a client disagrees with the psychologist but not the other way round, constructing this as a one way process. This account gives more credit to the psychologist's opinion, which does not require testing. Client disagreements with the psychologist's ideas are described as just that: *"if a client doesn't agree with you"* (line 21). When disagreeing with the client's ideas however the participant appears unwilling to disclose this and instead uses different language to frame the client's idea as a "*red herring"* (line 25). This idiom constructs the client's account as misleading or distracting from some other (possibly more truthful or useful) explanation. This difference in language may function to reduce discomfort associated with disagreeing with a client, given the discourse of collaboration drawn on throughout the extract and the construction of shared understanding as important.

The following excerpt contrasts with extract 6, and alternatively constructs testing out client beliefs as confrontational, non-collaborative and even harmful.

Excerpt 13 (Chris)

1. **I.** I know you said [CBT formulation] can have sometimes quite a
2. negative effect on people could you tell me a bit more about that sort
3. of negative impact
4. **P:** Yes because what you end up what I've found is you can end up
5. getting into a dynamic where you're asking the person to (.) do
6. something so you know (.) so you're saying well in some ways what

7. you're trying to do is get them a discrepancy between what they believe
8. and what the reality is but that actually involves them (.) that affects
9. their self esteem (.) Because actually (.) I'm invested in this view you
10. know I've believed this view for a long time, you know and now here
11. you are trying to come along and tell me my view's wrong and that
12. you're going to prove to me it's wrong that's quite a confrontational
13. that's not very erm (.) collaborative (.) that's quite confrontational so
14. we're coming from the basis that I'm right and you're probably wrong
15. so that's again that's why I tend to use it as an analogy rather than as
16. a therapy
17. **I:** And what would you say is the impact of using CBT as an analogy in
18. that sense then and the sort of using it as
19. **P**: Well if I'm using it as an analogy then you can allow the person to go
20. away and let it settle (.) you're you're not you're not trying to force
21. them to adopt it you're kind of going this is one way it can be
22. explained (.) some people find this useful but you're not then having to
23. try and challenge them on their symptoms

Three key features of talk were identified here. First was the construction of CBT formulation as confrontational and unhelpful. CBT formulation is described by Chris as trying to get *"a discrepancy between what they believe and what the reality is"* (lines 7-8). This practice is argued to affect clients' self esteem (line 9) as well as being confrontational and non-collaborative (lines 12-13). This can be seen as an alternative way of constructing practices such as reality testing experiments previously outlined in excerpt 12 as helpful and collaborative. This contrasting construction of CBT formulation for those with psychosis as inherently non-collaborative differs from previous accounts. It is important to note that although this particular construction follows invitation from the researcher to talk about the "negative effect[s]"; this followed Chris' previous descriptions of CBT formulation as "confrontational" and as having a "negative impact". Such descriptions followed a more general question from the researcher regarding the impact of CBT formulation for those experiencing psychosis.

Second, Chris uses a number of discursive strategies to persuade the listener of his argument. This includes speaking on behalf of the client in the first person to add credibility on lines 9-10: *"I'm invested in this view you know I've believed this view for a long time".* An extreme case conceptualisation is another rhetorical strategy utilised here to further persuade the listener that CBT is confrontational, saying on behalf of the client *"now here you are trying to come along and tell me my view's wrong and that you're going to prove to me it's wrong"* (lines 10-12). This could be viewed as a form of stake inoculation (Potter, 1996); that is Chris manages the risk of his account being discredited due to personal investment by using a client's voice to demonstrate that he does not have a stake in this view. The extreme case conceptualisation is continued on line 14 as the participant equates CBT practice to the psychologist holding the assumption that they are *"right"* and the client is "*probably wrong".* This can be viewed as a linguistic trick to persuade the listener of the dangers of CBT.

Third, Chris constructs an alternative to using CBT *"as a therapy"* (line 16) instead describing using CBT *"as an analogy"* (line 15, 19). Chris does not fully unpack what is meant by this but reports on lines 19-23 that using CBT in this way means he can *"allow the person to go away and let it settle"*, not *"force them to adopt it"* and not *"hav[e[to try and challenge them".* Using CBT as an analogy is constructed as a more collaborative and non-confrontational approach in which the participant may still offer an alternative but can accept if the client does not wish to adopt this alternative. The participant here draws on a discourse of non-collaboration as undesirable and unhelpful; again this positions collaboration as the preferred and ideal approach to CBT formulation.

This contrast between constructions of collaborative empiricism as helpful and collaborative, but also confrontational and harmful further highlight the complexities of this topic. This new description of CBT as an analogy appears to be a way of managing the discomfort associated with what is constructed to be a non-collaborative approach enabling the participant to still position himself as collaborative despite using a framework argued here to be confrontational.

Complete openness or keeping it simple?

The following two excerpts illustrate inconsistencies in discourses drawn upon regarding how open and honest to be with the client. For example whether openness and transparency is key to collaboration or whether it is better to keep it simple and only share what is deemed necessary.

Excerpt 14 (Marie)

1. **I:** I think we've already spoken a bit about collaboration and how you
2. would promote collaboration when you're developing a cognitive
3. behavioural formulation for someone experiencing psychosis (.) is
4. there anything that we've not mentioned already there about how you
5. would promote that collaboration
6. **P:** I think being <u>open</u> with the client (.) very much from an open honest
7. perspective (.) we want to have <u>mutual respect</u> within the therapeutic
8. relationship and you know talking to them (.) particularly as a forensic
9. service (.) I believe that there's always a power imbalance most of our
10. clients have been sectioned and had that power control taken away
11. from them so we would hope that within therapy one of the things
12. we're doing is trying to <u>empower</u> them to take responsibility for
13. themselves and we are trying to give them the <u>tools</u> for them to be
14. able to kind of internalise that and take that away and do it themselves
15. so if we talk to them about that and being open about that you know
16. obviously there is a power difference and that (.) you know we are
17. people who have keys clients don't (.) but there's community teams so
18. they do come and go (.) but obviously we have the power to recall them
19. if necessary (.) but being very open about this is the relationship this is
20. what we want to do we want to work together

The analysis of this extract indicates three key features of talk: constructing collaboration as working together and being open; Marie positioning herself as a collaborator; and constructing the power imbalance between psychologist and client as inevitable but also flexible. Collaboration is described as being *"open"* and *"honest"* (line 6) as well as having *"mutual respect"* and working *"together"* (lines 7-20). Marie argues that collaboration reduces the power imbalance by *"empower[ing] them to take responsibility for themselves"* (lines 12-13).

Collaboration is represented here as particularly important in a forensic setting, as Marie reports *"most of our clients have been sectioned and had that power and control taken away from them"* (lines 9-11). Marie describes this in the past tense which may serve to distance her from any involvement with this removal of power and control. This may represent discomfort associated with ideas of removal of power and control, in line with common discourses which hold collaboration and equality as ideal within mental health work.

Describing actions taken to achieve collaboration such as being open, honest and working together can be seen as a way of Marie positioning herself within the interview as a collaborator. Marie talks about *"giving them tools"* and *"trying to empower them to take responsibility"* and *"do it themselves"* on lines 12-14. This language can be viewed as further positioning herself as a facilitator; offering tools to help the client solve the problem themselves. However, phrases such as *"giving them"* and *"empower them"* also conversely position Marie as an expert helper with tools to help the client. This constructs collaboration as complex and that there may be different levels of collaboration. Also, the word empower here constructs the notion of encouraging client responsibility as empowering. Alternative constructions around responsibility such as implications of blame or invalidating previous experiences are not considered here.

The power imbalance is constructed as inevitable as Marie states "*there's always a power imbalance"* (lines 8-9) in forensic services and later *"obviously there is a power difference"* (line 16). The use of the word obviously further argues this is inevitable and expected within the context; this is inconsistent with reported aims to empower clients, which alternatively construct this as changeable. It is interesting that the participant reports that talking about and being open about power differences (lines 15-16) somehow promotes collaboration. This constructs the action of acknowledging power differences as powerful, with inevitable consequences of collaboration. This removes responsibility of the psychologist to address such power differentials and instead constructs it as sufficient to talk about and acknowledge these. This

further reduces opportunities for the client to become an equal collaborator as such power differences are constructed as fixed and unchangeable.

This account demonstrates contrasting discourses drawn upon by Marie of collaboration as the ideal alongside collaboration as limited in certain settings, highlighting challenges for collaboration particularly within settings when the service-user is not there voluntarily. Additionally, openness and transparency are constructed as key to collaboration contrasting with extracts 3-5 in the journal paper which constructed dangers of openness and transparency. The next account alternatively constructs that sharing less with the client, by making formulations simple, is more collaborative and helpful.

Excerpt 15 (Gregg)

R: Yeh and so I guess (.) it sounds like you would tailor that to the individual and so now I guess it seems like you've started maybe simplifying those formulations more than you did previously has that changed the way that clients have responded to those explanations and formulations

P: Erm (.) they'd probably prefer a simpler one so yeh ((laughing)) I don't feel as good a psychologist I probably feel more like I'm doing it feels sometimes more like it's pop psychology I mean when you're not doing really complex it's just a simple thing (.) yeh I get more of a sense of professional pride out of a more complex one (.) with bidirectional arrows but no it's probably that's probably more about my needs than about the client's needs so I think it's probably better just to have something simple (.) the client feels like they have more of a stake in it (.) more of a collaborative thing you know (.) I know with some of the younger staff in the department I guess they've been trained in much more of a (.) their training is much more of a collaborative one when working with service users and listening much more to them so I see them writing really good letters to clients where the letter kind of has a formulation in it a kind of shared formulation making that really explicit and I think that's really good I think it's too late for me to change into that way of working but it is I think that's a better way of sharing a

22. formulation is through those therapeutic letters you know (.) not just
23. the CAT letters but whatever model (.) the younger psychologists do a
24. better way have got a better way I think of sharing a formulation than I
25. have

Two main points of analysis are discussed here. First, collaborative formulations are equated with simple formulations. On lines 12-14 Gregg describes that it is *"better"* to have a *"simple"* formulation, constructing simple formulations as *"more of a collaborative thing"* that the client has *"more of a stake in"*. This construction of collaborative formulations as simple has not been seen in other extracts. Gregg draws on discourses of collaborative formulation as *"better"* than non-collaborative formulation for the client, stating on line 6 *"they'd probably prefer"* a simpler formulation, constructing simple collaborative formulations as better meeting *"the client's needs"* (line 12).

Interestingly Gregg constructs his own needs and preferences as conflicting with the client's, reporting that he does not *"feel as good a psychologist"* (lines 6-7) and that it feels more like *"pop psychology"* (line 8) when developing a simple formulation. Furthermore he reports gaining *"more of a sense of professional pride"* (line 10) from complex formulations despite these being constructed as less collaborative. Gregg reflects that *"that is more about [his] needs"* however. This account positions the participant as sacrificing of his professional pride for the client's benefit; this may serve to position the participant in a favourable light within the interview, as altruistic and understanding of client needs. Language used in this account, such as equating simple formulations to *"pop psychology"* and using the word *"thing"* (lines 4, 9) to talk about simple and collaborative formulations makes the comment appear blasé and flippant and can be seen as a discursive strategy serving to weaken the credibility of this discourse and persuade the listener to take a dismissive stance towards this version of formulation.

The second point is the way Gregg constructs the practice of younger colleagues as different from his own. It is reported that "*their training is much more of a collaborative one"* (line 16) when referring to *"younger staff"* in the service. Younger staff writing letters to clients with the explicit formulation in it is

praised by Gregg on lines 18-24. Collaboration is here constructed as developing an explicitly *"shared formulation"* (line 19) with clients and *"listening much more to them"* (line 17). Gregg distances himself from this practice of younger colleagues and from collaboration despite constructing this as a better approach, claiming *"I think it's too late for me to change into that way of working"* (lines 20-21). This discursive strategy justifies the reported lack of collaboration and removes responsibility from the participant to change his practice as this is constructed as not being possible, closing opportunities for Gregg to change his practice and to learn from younger psychologists.

This account constructs both collaborative working and non-collaborative working within CBT and does not therefore construct this approach as automatic or inherent within CBT, rather as something that requires a certain type of training and the sacrificing of "*professional pride*". This excerpt equates collaboration with developing simple formulations, arguing that less is more; this is inconsistent with the previous extract in which complete openness and honesty is constructed as necessary for collaboration.

Subjectivity of collaboration

The next three extracts construct collaboration as requiring particular qualities or characteristics of the practitioner.

Excerpt 16 (Jennifer)

1. **I:** Thank you and would you say that there are any differences in that in
2. how you would promote collaboration with people experiencing
3. psychosis than how you would with any other client group
4. **P:** I think it involves more erm (.) ability to tolerate your own anxiety and
5. about (.) and this is perhaps about, in inverted commas (.) colluding
6. with things you know because people will say you know oh well if
7. you're just accepting that these voices are really I dunno aliens or
8. government spies or whatever then you're just agreeing with them (.)
9. and it's like well no that's so actually it's not about collusion it's about
10. being able to erm hold and tolerate and accept different perspectives

11. without <u>having</u> to go to have a singular truth or right

In this extract Jennifer is invited to comment on the differences in how she promotes collaboration with people experiencing psychosis; this invitation constructs those with psychosis as different to other groups and therefore requiring a different approach. Jennifer describes the main difference as being able to *"tolerate your own anxiety"* (line 4) due to the possibility of other people suggesting she is *"colluding with"* clients' beliefs (line 5) if she is accepting of these. The word "*collusion*" constructs such accusations as derogatory and negative which is emphasised by initial comments that this is anxiety provoking for Jennifer. The phrase "*in inverted commas*" (line 5) is used to precede the term colluding; this discursive strategy functions to cast doubt over the term and persuade the listener that this is not an accurate description of the participant's practice. On lines 9-10 the participant constructs a difference between *"collusion"* and *"accept[ing] different perspectives".* Here Jennifer positions herself as accepting of different opinions and able to *"tolerate"* these, conversely positioning those who consider this as collusion as not being able to tolerate difference.

In this extract the psychologist (as in extracts 6 and 10) constructs collaboration as involving acceptance of different opinions. Interestingly this is argued here to be more challenging and anxiety provoking with this client group due to others viewing this as a form of collusion with unusual beliefs held.

Excerpt 17 (Jennifer)

1. **P:** If I went in and tried to tell them to do something else they'd tell me to
2. sod off you know ((laughing)) and I would too if someone came to me
3. and said (.) no what you think is completely wrong I'd be like no I don't
4. want to work with you (.) so it's about knowing that, then things might
5. change over time (.) or things might not change over time but that if
6. people can function and work they can believe we all hold different
7. beliefs about sort of spiritual religious political views you know so I
8. think it's about respect and entitlement

Jennifer constructs unusual beliefs held by someone with psychosis as falling on a continuum here, and normalises this by stating *"we all hold different beliefs"* and drawing on common differences in beliefs such as *"spiritual religious political views"* (lines 6-8). This reminds the listener that many people without psychosis have beliefs which may not be shared by others, but that it is possible to be accepting of such differences. Holding particular beliefs is constructed as an *"entitlement"* (line 8) drawing on a rights discourses previously seen in extract 6. This construction empowers clients with psychosis and validates these beliefs.

Jennifer uses a rhetorical device of putting herself in the client's shoes to build the argument for an accepting approach. On line 2 Jennifer claims that she would have a similar response to the client if someone said *"what you think is completely wrong",* reporting that this would lead to her to not want to work with that person, normalising this response. This constructs that accepting different beliefs facilitates engagement. This acceptance of different beliefs without apparent agenda to change these can be seen as offering more power to the client whose beliefs are taken seriously and accepted. This shares similarities with the construction of collaboration purported in excerpt 9. Both extracts 16 and 17 construct a subjectivity of collaboration, describing this as relying on qualities intrinsic to the psychologist e.g. being able to tolerate and accept multiple opinions.

Extract 18 (John)

1. **I:** We've already spoken quite a bit about the importance of the
2. therapeutic relationship (.) in terms of collaboration when developing a
3. CBT formulation for somebody experiencing psychosis do you think
4. there are differences in how you promote that collaboration (.) for this
5. client group
6. **P:** I think there are but I wouldn't be different with anybody I was working
7. with (.) I think this is just what I do now (.) I think in more highly
8. pressurised services you don't have the time to know the person (.)
9. you don't get the time to really let them get a feel for you either (.)
10. you're there as a professional rather than as I guess at some level as

11. a collaborator in their recovery (.) so it's not a partnership it can't feel
12. like a partnership when you've got that highly pressurised sense of it
13. so you're always there in the expert role (.) now some people respond
14. fabulously to that and they see it as that's all they want you for but
15. other people who've had more damaging experiences or more
16. confusing experiences don't just want to see another professional
17. they actually want a sense of the person behind the badge the label
18. the you know the demeanour (.) they need the human being as part
19. of the process (.) and I think that's very important I think it's very
20. important for people with psychosis I also would say it's important for
21. people with you know long term trauma experiences and damaged
22. ways and relating to others

There are two key features of talk within the analysis of this extract. First, as seen in extract 14, the service is constructed as inhibiting collaborative formulation. On lines 8-9 John talks about not having *"the time to know the person"* or *"the time to really let them get a feel for you either"* claiming this is due to *"highly pressurised services"*. This discursive strategy attributes non-collaborative working to time constraints of the service and positions John as lacking in personal agency, constrained by wider systems with little power to change such factors. The word *"can't"* on line 11 emphasises this. On lines 10 and 13 John talks about his role as being as a "*professional"* and "*expert";* this is constructed as an alternative role to one of *"collaborator"* or "*partner[ship]"* (lines 11-12). Again this role as non-collaborator is attributed to the *"highly pressurised"* nature of the service (line 12). Using the word *"you're"* (in an expert role) on lines 10 and 13 can be seen as a discursive strategy through which John is careful not to align himself personally with this position, instead constructing that this is applicable to all those working in such services.

Second, this account constructs collaboration as an ideal although one that is not always possible due to service constraints. This is demonstrated by the change in language from line 17 as the participant again begins speaking in the first person when describing the importance of showing the *"person behind the badge"* and the *"need [for] the human being"* (line 18) when working with people

experiencing psychosis and long-term trauma. Describing *"I think"* and *"I would say"* on lines 19 and 20 when talking about this human approach can be seen as a way of John positioning himself within the interview as in favour of this more collaborative, human approach and as constructing this as an ideal.

This account interestingly constructs more of a need for a collaborative approach when working with people experiencing psychosis but also constructs the service worked in as reducing opportunities for this approach. As with extracts 16 and 17 this account again subjectifies collaboration; constructing this is something inherent within the person *"behind the badge"*. However this seems inconsistent with other constructions in this account that collaboration is dependent upon the service constraints.

Performing collaboration in the interview

In addition to the many extracts that have demonstrated ways participants have constructed collaboration and positioned themselves in relation to this, this extract alternatively illustrates a participant actively performing collaboration within the interview.

Excerpt 19 (Carol)

1. **I:** OK and <u>how</u> would you say that you go about developing a CBT
2. formulation for psychosis (.) I know that's quite a broad question
3. **P:** That is very broad one isn't it (.) how do I go about developing it (.)
4. Erm (.) I tend to write quite a lot (**I:** umm) so I'll have the paper in the
5. room so that from the very first session kind of the opening question
6. might vary (.) but kind of what's brought you here (**I:** yeh) or kind of
7. what's what's so as they're saying something I'll jot it down (.) so it's
8. about <u>mapping</u> (.) the formulation starts straight away with the <u>mapping</u>
9. so (.) it's shared and collaborative from the start because it's there so
10. you might say oh okay so you're telling me about this and if you identify
11. a particular erm (.) <u>that varies again</u> (**I:** umm) 'cause the direction you
12. go depends on what they give you (.) so if somebody gives you an
13. emotion then we'll kind of oh okay what led to that what led to this

14. (.) or if somebody gives you a thought then it's (.) oh well how did that
15. make you feel (.) or if someone gives you a physical sensation oh I
16. wonder what that was did you feel it anywhere else (.) is there a word
17. that comes with that or erm so it's quite creative I think that's kind of
18. that's one of the things I love about the job I guess is that you
19. constantly you need to be really flexible and adaptable and (.) so it's
20. kind of if somebody says oh they made me feel really small oh okay
21. so what did that make you feel what did that make you think how did
22. you feel about yourself there so you're identifying the core beliefs and
23. the automatic assumptions and the kind of thinking styles

Carol reports that the formulation is *"shared and collaborative from the start"* (line 9). 'Mapping' is described to play an important role in this collaborative formulation (line 8); this is outlined as a process of *"jot[ting]"* down what clients are saying (line 7) and asking client questions to facilitate links to be made between factors such as emotions, thoughts and physical sensations on lines 12-17. This positions Carol as an equal collaborator with the client and as a facilitator rather than expert. This account constructs collaborative formulation as one which is jointly developed in the session as an interactional or dialogic process between both the psychologist and client. This fits with constructions of collaboration as jointly produced in extracts 1 and 5.

Carol here role plays a list of potential questions she may pose to a client (lines 9-17), performing collaboration within the interview in order to align herself firmly with collaboration. Questions starting with *"I wonder"* are also described here positioning Carol as tentative in her suggestions to the client and therefore as open to the possibility that ideas may not fit with the client's perspective. This distances her from an authoritarian position. On line 22 Carol says *"you're identifying the core beliefs"* positioning the psychologist as responsible for developing these aspects of the formulation and constructing that at times it is the psychologist who is playing the main role in formulating rather than this being a joint responsibility.

Describing constructs such as *"emotions*" and *"thoughts*" here again constructs a subjective self; that is clients are constructed as having these internal

experiences that are accessible and can be communicated. This draws on wider discourses in mainstream psychology as well as within wider society about the individual, subjective self (see Rose, 1990 for further discussion) and this construction fits with constructions offered by CBT about the link between thoughts, feelings and beliefs (e.g. Westbrook, Kennerley & Kirk, 2011).

Both researcher and participant describe that the question posed about how the formulation is developed as a *"broad"* question (lines 1-3). This constructs formulation as not a simple and straightforward process that can easily be explained, but as variable and unwieldy. Carol's repetition of the question emphasises this. Formulation is also described as an individual process; Carol reports on lines 5 and 6 that the *"opening question might vary"* constructing this process as flexible and not rigid. The use of tentative terms such as "*kind of"* (lines 5-6, 13, 17, 20) and statements such as *"cause the direction you go depends on what they give you"* (lines 11-12) describe this process as flexible and idiosyncratic and also may justify the participant not having a straightforward answer to the question about the process of formulation.

This excerpt illustrates the construction of collaborative formulation as developed jointly through a dialogic process within the session. This account can be viewed as empowering the client, as their perspectives are credited and incorporated into the continuously developing formulation. This extract differs from previous as instead of just constructing collaboration through descriptions, it is performed in the interview through offering a host of questions that are presented as collaborative.

EXTENDED CONCLUSIONS

This analysis illustrates a number of dilemmas that participants oriented themselves to in their talk about collaborative formulation in CBT for psychosis. This included clients' rights to hold a different perspective to the psychologist, how to resolve disagreements or differences regarding the formulation, and how open and transparent to be with clients. The analysis highlights tensions between conflicting discourses drawn upon by clinical psychologists working within this context such as 'collaboration as the ideal' but also 'openness and transparency as dangerous' as well as the 'importance of a shared understanding' alongside 'accepting multiple perspectives'. Constructions of collaboration were again diverse and variable and included collaborative formulation as 'shared with' or 'presented to' the client, 'developed with' and as a constant process of 'checking out' or requesting feedback. The way collaboration was constructed in accounts opened up or closed down opportunities for action and had implications for power. The subjectivity of collaboration was also constructed in accounts alongside contrasting descriptions of this being service and training dependent. Furthermore whilst collaboration was frequently presented as simple and straightforward by participants, accounts quickly moved on to depict complexity and ambiguity within this construct.

A salient and consistent feature of analysis was the way participants firmly positioned themselves as aligned with collaboration as well as using discursive strategies within the interview to perform collaboration. Participants were keen to position themselves as equals within the relationship and often minimised or neglected the power inherent to their role of therapist. This seemed inconsistent with other positions adopted however such as 'expert', 'protector' and 'helper' of the client which implicitly positioned participants in a position of power, often making decisions on behalf of and in the 'best interests' of clients. Discourses of ethical and professional duties were frequently drawn upon to justify these alternative positions. Clinical psychologists frequently spoke of 'empowering' the client. The rhetoric of 'empowerment' has been criticised (Parker, 1999 in Proctor) as betraying something of the position of the expert, who thinks they

are able to do more than helping the person. Furthermore, rhetorical strategies used in accounts to promote credibility of the psychologist's formulation and in turn weaken the credibility of clients reported understandings again appear at odds with the position of collaborator. It has been suggested that the client's acceptance of the therapist's authority is seen as a necessity for CBT and when a client disagrees or does not comply with the model, this is seen as a set back or opportunity to challenge the client's thoughts and beliefs (Proctor, 2002). This was at times seen in participants talk about CBT, particularly when rational explanations were applied to disagreements discussed, for example stating that this was an 'avoidance' of the client or a 'coping strategy'.

The lack of openness and acknowledgement of these power differentials calls for such issues to be highlighted and discussed both within the profession of clinical psychology and CBT. It has been suggested that discourses of collaboration can conceal the power of the therapist (Lowe, 1999). Furthermore, by not openly acknowledging such positions of power, this may reduce opportunities for psychologists to discuss such issues openly in supervision, and potentially leaves clients more vulnerable to abuse or violation of power within the relationship if this is not accepted and therefore appropriately monitored or regulated. Common discourses of collaboration need to be questioned and there is a need for more acknowledgement and openness of the limits of collaboration, and power inherent within the role of the therapist. By acknowledging such issues explicitly through supervision, training and within the CBT literature, measures can be taken to monitor use of power and ethical dilemmas arising.

This research highlights tensions and complexities present in clinical psychologists' talk about collaboration along with the multiple ways this can be constructed and contradictory discourses drawn upon. The analysis illustrates that current conceptualisations of collaboration within the CBT for psychosis literature which often present this as a straightforward concept, are inadequate (e.g. Fowler *et al.*, 1995). Inconsistencies within discourses drawn upon in the literature which position practitioners as collaborators alongside educators (e.g. Morrison *et al.*, 2004), and clinical psychologists specifically as expert

formulators (Kinderman & Tai, 2007) are reflected in tensions presented here. This supports concerns suggested by Overholser (2011) about the challenges for collaboration within CBT given the differing roles adopted by therapists when using this approach. Findings here are consistent with research into service-users' experiences of CBT for psychosis which has also illustrated discrepancies between constructions of 'CBT as a respectful relationship between equals' and 'CBT participation as compliance with the powerful medical establishment' (Messari & Halam, 2003). Furthermore inconsistencies within therapists' discourses about CBT: as 'a collaborative educational process' and 'a respectful relationship between equals' but also 'modification of patients' paranoid beliefs' (Messari & Halam, 2003) also fits with the findings of the current study.

Tensions presented here also support previous claims that the wide gap between therapist and client view of the world and concerns about disengagement can lead to challenges when formulating collaboratively with clients experiencing psychosis (Fowler *et al*., 1995). The construction of the dangers of sharing formulations openly alongside accounts constructing the importance of openness and transparency by participants is consistent with literature demonstrating the wide range of responses to CBT formulations seen with clients experiencing psychosis e.g. as saddening and worrying but also helpful (Pain *et al*., 2008). That participants aligned themselves firmly with collaboration and drew on discourses of collaboration as the ideal indicates that these discourses dominant within the literature have been adopted by clinical psychologists. This parallels research that has indicated that for service-users, collaboration is a highly valued part of CBT for psychosis (Kilbride *et al*., 2013).

Implications

The research highlights that collaboration may be more usefully constructed as being made up of a range of approaches rather than as a singular way of working. For example as developing formulations in session with the client; sharing the formulation with the client and requesting feedback; developing a simple or complex formulation; agreeing to disagree or developing a shared understanding, all according to client needs and preferences. It could be

suggested that the therapeutic alliance may also be viewed in this multi-dimensional way, with an open and actively involved (collaborative) partnership being just one of many possible alliance types, as discussed by Bachelor (1995).

It may be useful to consider an approach similar to the 'matching hypothesis' seen in health and social psychology literature when determining type of collaboration and therapeutic alliance suitable for the individual. This approach has been used to match type of social support to needs resulting from a particular stressor (Cutrona, 1990) and to match health messages to information-processing styles (Williams-Piehota, Schneider, Pizarro, Mowad & Salovey, 2003). It may be that some service-users prefer or respond better to an approach in which there are high levels of openness and transparency or in which they can take the lead in determining therapeutic activity, whereas other service-users may prefer or respond better to approaches in which the psychologist takes the lead or offers more simplistic formulations and understandings. However, using such an approach in CBT for psychosis may entail several challenges and complexities that differ from those encountered when matching methods of communication for health messages. For example the service user may not know what sort of collaboration they would prefer or benefit most from. Furthermore there may be challenges in communicating this openly to the therapist, particularly if this conversation is held at the beginning of therapy and prior to developing a therapeutic rapport. Power differentials and viewing the therapist as an 'expert' may also influence the service user's ability to communicate their wishes and needs honestly. The style of collaboration may fluctuate naturally between sessions, therapeutic activities, and during the course of therapy; guided by both therapist and service user. This fluid process could be compromised if the approach was rigidly contracted at the beginning of therapy.

Clinical psychologists are called to carefully consider modes of collaboration drawn upon when formulating in CBT for psychosis and think about how these decisions are made and how they know the particular approach chosen will be best for the service-user. Reflection and openness on types of collaboration

within supervision and training is also recommended to help practitioners make more informed and explicit decisions regarding collaborative approach taken and ways of managing different positions adopted.

It may be helpful for the research to move away from simplistic notions of measuring the value of 'collaboration' or 'therapeutic alliance' by investigating the impact on treatment outcomes until these constructs have been fully defined and operationalised and the complexities and differing types of alliance and collaboration taken into account. Research seeking to operationalise and better define what is meant by collaboration is called for, particularly within CBT for psychosis which offers an extra layer of complexity for this topic (as discussed by Tee & Kazantis, 2011). Furthermore, future research is called for which unpicks collaboration from the therapeutic alliance and can further define these constructs and the overlap but also differences between the two. It would be beneficial to further investigate these different types of collaboration and to possibly create a taxonomy of collaboration types; further research with service-users to investigate preferences and benefits of different types of collaboration within CBT for psychosis would aid this process.

Additionally, there is a paucity of research looking at the dangers of formulation in CBT for psychosis, and it may be helpful for future research to consider these as well as ways of overcoming such dangers. One discourse frequently drawn upon by participants was 'dangers of openness and collaborative formulation'. Future studies investigating this would help clinical psychologists make informed decisions about sharing formulations with service-users.

Limitations

The epistemological stance taken in this research is not without its limitations. From a social constructionist perspective the findings are viewed as one of many possible constructions rather than as revealing an underlying truth. Whilst the idiosyncrasy or lack of generalisability of findings of this approach could be seen by some as a limitation, this approach allowed for the multiple constructions presented to be attended to and was sensitive to diversity and contradictions within the findings. It is acknowledged that this particular analysis

was co-constructed by interviewees, the researcher and through supervision, and that a different set of analyses with different features picked out as 'salient' may have been presented by an alternative researcher although both of which may have utility. It is not suggested that this study captured all possible constructions of collaboration but rather some of the discourses available to clinical psychologists.

Furthermore quality guidelines by Madill *et al*. (2000) were considered throughout the research process and this thesis has aimed to present as much transparency as possible within the limitations of the word count, for example extracts of transcripts were presented along with analysis in order to demonstrate that interpretations were credible, coherent and grounded in the data. Madill's notion of deviant case analysis was also drawn upon and material was sought to demonstrate exceptions and contradictions within accounts. Additionally as a first time discourse analyst the researcher had limitations in experience in using this approach. Reading other discourse analysis studies and textbooks as well as using supervision and personal reflection assisted with the researcher's development in learning this method however.

One main challenge of this research was that it did not initially set out to be a discourse analysis study or to focus specifically on collaboration. The initial plan for the project was to complete a grounded theory study from a critical realist perspective, investigating how clinical psychologists formulate in CBT for psychosis. The interview schedule was broad and looked at various aspects of the formulation process. If the initial aims of the study had been to investigate talk about collaboration, the questions would have focused more on this topic, for example asking participants what they understood was meant by collaboration and more details about challenges around collaboration and times when collaboration was viewed to be helpful or unhelpful. As a grounded theory approach was initially taken, the interview schedule was amended as the previous analysis progressed. A theme of 'collaboration dilemmas' was identified in the previous analysis so the interview schedule was amended to ask more about collaboration e.g. how this was promoted within the formulation process. However having the focus on formulation rather than solely on

collaboration proved to be a good site for talk of collaboration and may have led to a more subtle understanding of constructions of collaboration than if participants had been explicitly talking about collaboration per se. Furthermore, if a discursive approach had initially been taken for the study, I may have been more attuned to discursive features within interviews or particular discourses drawn upon which could have led to different follow up questions or amendment to the interview schedule.

The broad approach taken also led to difficulties during the interviews; although the interview questions focused on CBT formulation, as other theories were often reported to be integrated it is difficult to draw firm conclusions about CBT formulations specifically. It may have been difficult for participants to consider CBT formulations specifically given that it was reported by participants that a range of theories tended to be drawn upon when formulating. The abstract nature of the concept of formulation and collaboration also lead to difficulties during the interviews, as participants often seemed unsure about what I was meaning by the word formulation. I attempted not to lead clients with my own views about formulation, instead indicating that I was interested in their views on formulation, what it was and how this process was conducted.

Furthermore, a lack of explication in the participant invitation letters of what was meant by using CBT for psychosis seemed to lead to a number of potential participants self-excluding from the study. More detail as to the broad range of ways CBT may be used that would have been acceptable to the study could have reduced this. This may have attracted a different sample of participants, possibly of those more critical of CBT which could have led to a different set of accounts and therefore analysis and conclusions.

REFLECTIONS

Conducting this research has challenged my thinking about collaboration. When beginning this project, like the participants I drew on discourses of collaboration as the ideal, constructing this as a single approach. I attempted to put this into practice by offering choice to clients, aiming to develop formulations in session where possible and listening to and respecting clients' own understandings. I did not question the construct of collaboration; rather I questioned my skills in collaborating if I had challenges in implementing this approach. For example, there have been times, especially when learning a new psychological model or approach that I have felt it is beneficial to formulate outside of the session and then share this with the client and gain feedback, as it has taken time, thought and use of supervision to develop the formulation in line with the model. I have had mixed feelings about this and have previously reflected that this is not as collaborative as producing this in the session with the client which I have regarded as ideal, whilst feeling at the same time that this was more beneficial to the client and would be smoother than attempting this in the session when I was struggling to make sense of the model.

Furthermore, on other occasions I have offered clients choices for example about the type of psychological therapy to utilise, giving a brief summary of two approaches and asking the client which they think may be more beneficial. I viewed this as ultimate collaboration and empowerment of the client. However the response of confusion and almost panic from the client who suggested that they did not understand either enough to make that decision and wanted me to make this decision left me reflecting that such choice although may be wanted and valued by some, to others could seem overwhelming. In light of this research I may now be more open to thinking about different types of collaboration and that it is about considering what is best for the individual client in the individual situation rather than attempting to take one approach with all clients. I have become more reflective and curious about collaboration within my practice and constructions of this. For example in recent sessions with a client experiencing psychosis I have considered decisions made by myself and the clinical psychologist I am jointly working with not to share openly our initial

thoughts about formulation. This research has made me more questioning about the reasons for this. For example I have considered that openly sharing our initial and tentative formulation could conversely reduce future opportunities to jointly develop an understanding with the client following further developing the therapeutic relationship and facilitating the client's views and understandings to be heard which can then inform this. This contradicts common discourses that openness and transparency is always collaborative and again suggests this is dependent on the individual situation.

Additionally, using a discourse analysis approach has influenced my practice. I have become more attuned to mine and others' use of language and to considering the function of language within the local interaction, wider discourses drawn upon and implications of this for power and action. For example, in a conversation with a client about stigma he felt he had been subject to due to his mental health problems led to a conversation about how people talk about mental health within society and discussions about the implications of this on his experience for example believing himself "inferior", employment opportunities etc. Considering wider discourses and maintenance of these e.g. through the media helped externalise the client's subsequent beliefs about himself and to put these in context.

Interestingly prior to beginning this second project and despite taking a social constructionist perspective on many issues, I was reluctant to adopt a social constructionist perspective for research as I did not understand how it would be possible to draw useful conclusions from this that would have helpful implications. Having decided to utilise a discourse analysis methodology however, I viewed that a social constructionist stance would be most appropriate for this study. I found learning and practicing this methodology more challenging than anticipated as it required a shift in world view and way of describing and analysing peoples' talk. I had not previously reflected upon how much I automatically adopt a perspective that is accepting of constructs such as 'beliefs', 'attitudes' and 'views'. It was a real struggle to adapt this to considering instead peoples' 'constructions', 'discourses drawn upon', and action of language, particularly when writing up this study. Even writing this reflective

section I am aware of the difficulties of keeping up this approach, as I automatically want to discuss how my ‘views’ and ‘beliefs’ have changed. It seems almost impossible to separate myself from such dominant discourses.

Using this approach has highlighted to me the value that this type of research can have and that it is possible to draw useful conclusions from social constructionist research. This is more apparent when I compare this to the critical realist perspective taken in the previous grounded theory study. From this perspective, findings were still viewed to some degree as co-constructed with participants, although the method offered less opportunity to deconstruct this and consider influences on these constructions. The analysis resulted in more ‘textbook’ descriptions of formulation and a lack of depth of analysis. A discourse analysis approach has alternatively allowed more for variability and contradictions. From a discourse analysis perspective such inconsistency could be drawn upon as points of interest rather than being grouped into particular themes. Investigating functions of language within the local interaction, as well as considering wider discourses drawn upon enabled a more in depth analysis of participants talk about this subject and highlighted several areas of inconsistency and tensions for participants. I would therefore be inclined to use a social constructionist and particularly a discourse analysis methodology again in the future.

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APPENDIX A

Version 3 (31.10.12)

Letter of invitation

Dear

I am writing to invite you to take part in a study which is being conducted in partial fulfilment of the requirements of the Trent Doctorate in Clinical Psychology. The study aims to explore how Clinical Psychologists use cognitive behavioural formulations when working with people experiencing psychosis. If you decide to take part, an interview will be arranged at a time and place convenient to you and would last approximately one hour.

If you do not use CBT for individuals with psychosis then unfortunately you will not meet the criteria to take part in this study.

Enclosed is further information detailing what taking part would involve, the aims and background of the study, ethical considerations and how you can take part.

Yours Sincerely,

Laura Stone

Trainee Clinical Psychologist

APPENDIX B

Lincolnshire Partnership NHS
NHS Foundation Trust

Participant Information Sheet

Version 3 (31.10.12)

Study: How clinical psychologists formulate from a cognitive behavioural perspective with people experiencing psychosis: an exploratory study.

What is the study?

The study is aiming to recruit clinical psychologists who use cognitive-behavioural therapy (CBT) with people who experience psychosis. The study will explore how clinical psychologists develop and use formulations with this client group. This study intends to develop a theory about this process which will be grounded in the data collected.

Why is it important?

The ability to develop psychological formulations is a core competency for clinical psychologists according to the HCPC and BPS and a key principle in CBT. Despite this, literature in the field is scarce. Formulating within CBT for psychosis can pose different challenges to those faced with other client groups. This study therefore aims to address this gap by providing practice-based evidence about the process of CBT formulation for psychosis. The study will be useful for informing practice, training, increasing understanding and enabling further research in this area.

What will taking part involve?

If you choose to take part in the study then you should complete the attached tear off slip and return to Laura Stone, Chief Investigator. You will then be contacted to arrange an interview, if you prefer however, you can contact the Chief Investigator directly using the details provided to arrange the interview. This will be arranged at a time and place convenient to you and should last approximately one hour and will be audio-recorded.

Following this interview you **MAY** be contacted and invited to take part in a second interview, depending on the data gathered. However, as with the first

interview, this second interview is optional and if you decided not to take part then the data from your first interview could still be used. Figure 1 shows what would happen if you decide to take part.

Figure 1.

Do I have to take part?

Participation in the study is entirely voluntary and if you wish to take part you will be asked to sign a consent form prior to the interview. Participants have the right to withdraw from the study for up to 72 hours after the interview; this time period excludes weekends between Friday 5pm and Monday 9am. After this time, withdrawal of data will not be possible as data will be anonymised,

transcribed and analysis will begin. Additionally, participants can stop the interview at any point without giving a reason. If a participant withdraws from the study, then their data will be destroyed.

Could there be any adverse consequences of taking part?

There are no anticipated adverse consequences of taking part. However, if you were to disclose something that indicated a breach of professional guidelines then this information would have to be passed on. Initially this would be discussed with the project supervisor, if it is determined there are concerns regarding conduct or capability then the Chief Investigator's line manager would be informed and LPFTs policies and procedures e.g. Whistle Blowing would be followed. In addition, discussing the way you have used formulation with clients may bring up emotive experiences involving the clients you have worked with. Participants will be reminded of sources of support available to them including supervision and staff wellbeing and counselling services.

What are the benefits of taking part?

Potential benefits include the opportunity to reflect on how formulations are currently used in practice, this may lead to the development of the way in which you use formulation in CBT for psychosis.

Participants will also be asked for consent for the investigator to retain their contact details so that the findings of the study can be disseminated to participants following completion of the study, giving the opportunity to further understanding of this topic.

Ethical considerations

The study has received ethical approval from the University of Lincoln as well as Research and Development departments of participating trusts.

To ensure anonymity, all participants will be given a unique identification number and pseudonym in order to anonymise the data. Participants real names will not be used during the interview so the audio recording is anonymous. The research report and any other methods of dissemination (e.g.

conference presentations) will include direct participant quotes but these will be anonymous and not include any identifiable information.

In accordance with University of Lincoln guidelines and the Data Protection Act (1998), all identifiable and anonymised data will be stored in a locked filing cabinet at the University of Lincoln. The data will be held for 7 years (in line with the Data Protection Act 1998) and then destroyed.

All electronic data (i.e. audio recordings) will be held on an encrypted, password protected memory stick.

How do I take part?

Please complete and return the tear off slip stating whether or not you wish to take part in the study. You will then be contacted to arrange an interview. Alternatively, for further information or to arrange an interview, please contact Laura Stone, Chief Investigator:

Complaints

Any complaints about the study can be directed to

Dr Anna Tickle, Research Supervisor, tel: 0115 846 6646,

email: anna.Tickle@nottingham.ac.uk

Dr Sharron Smith, Line Manager, tel: 01522 837012, email: shsmith@lincoln.ac.uk

Laura Stone, Trainee Clinical Psychologist, address: Doctorate in Clinical Psychology, Faculty of HLSS, University of Lincoln, 1st Floor, Bridge House, Brayford Pool, Lincoln, LN6 7TS, email: 11235770@students.lincoln.ac.uk

Thank you for considering whether you would like to take part in this research study.

Yours Sincerely,

Laura Stone

Trainee Clinical Psychologist

.....

Name: **Place of work:**

Email: **Telephone number:**

Please tick box accordingly

☐	**I am interested in taking part in the study, please contact me to arrange an interview**
☐	**I do not wish to take part**

APPENDIX C

UNIVERSITY OF LINCOLN

08-10-2012

Dear Laura Stone,

The Ethics Committee of the School of Psychology would like to inform you that at our meeting on the 3.October.2012 your proposal 'How clinical psychologists formulate from a cognitive behavioural perspective with people experiencing psychosis.'

was:

☐ **approved**

☒ **approved subject to the following conditions:**

1 Extend the 72 hour contact period to account for weekends on specify an alternative.
2 Specify to whom disclosures of unprofessional behaviour will need to be "passed on"
3 Delete asking people for reasons they do not wish to take part or specify how this will be used.
4 Specify who to contact if there is a complaint
5 Make explicit to participants that they can stop at any time
6 Demonstrate that Appendix D information cannot be used to identify participants i.e. might some be used in any subsequent publication allowing individuals to be identified.

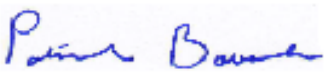
☐ **invited for resubmission, taking into account the following issues:**

☐ **is rejected. An appeal can be made to the Faculty Ethics Committee against this decision (cawalker@lincoln.ac.uk).**

☐ **is referred to the Faculty Ethics Committee. You will automatically be contacted by the chair of the Faculty Ethics Committee about further procedures.**

Could you address each of the issues raised by changing all relevant documentation, and by formulating a reply to each of the numbered issues in a separate document or e-mail? I may be able to approve after your reply by chair's action; if I have any doubts I will need to refer your application back to the School's Ethics Committee.

Yours sincerely,



Patrick Bourke, PhD

Chair of the Ethics Committee
School of Psychology
University of Lincoln
Brayford Campus
Lincoln LN6 7TS
United Kingdom
telephone: +44 (0)1522 886140

APPENDIX D

Lincolnshire Partnership NHS
NHS Foundation Trust

Ref:LS/CB
Date:24th January 2013

Research and Effectiveness Team
Trust Headquarters
Unit 9, The Point
Lions Way
SLEAFORD
Lincolnshire
NG34 8GG

Tel: 01529 222206
Fax: 01529 222226

Ms Laura Stone
Trent Trainee Clinical Psychologist
Doctorate in Clinical Psychology
University of Lincoln
Faculty of Health Life and Social Sciences
1st floor Bridge House
Brayford Pool
LINCOLN LN6 7TS

Dear Laura Stone

Study title: How Clinical Psychologists formulate from a cognitive behavioral perspective with people experiencing psychosis: An exploratory study

Date of permission: 24th January 2013

List of all site(s) for which NHS permission for research is given: Lincolnshire Partnership NHS Foundation Trust

NHS permission for the above research has been granted by Lincolnshire Partnership NHS Foundation Trust on the basis described in the application form, protocol and supporting documentation.

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP and NHS Trust policies and procedures (available at http://www.lpt.nhs.uk/).

Permission is only granted for the activities for which a favourable opinion has been given by the REC [and which have been authorised by the MHRA]

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.

The Research and Effectiveness office should be notified, at the address above, that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The Research and

Effectiveness Office should be notified within the same time frame of notifying the REC and any other regulatory bodies.

Any research carried out by a Trust employee with the knowledge and permission of the employing organisation will be subject to NHS indemnity. NHS indemnity provides indemnity against clinical risk arising from negligence through the Clinical Negligence Scheme for Trusts (CNST). Further details can be found at Research in the NHS: Indemnity arrangements (Department of Health 2005).

All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please inform the Research and Effectiveness department of any changes to study status.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

We are pleased to inform you that you may now commence your research. Please retain this letter to verify that you have Trust permission to proceed. We wish you every success with your work.

Yours sincerely

Dianne Tetley

Dianne Tetley
Assistant Director Research and Effectiveness
Lincolnshire Partnership NHS Foundation Trust

Cc Clinical Lecturer : Dr Anna Tickle – University of Nottingham International House B Floor
Clinical Psychologist : Dr Justine Hardy Clinical Psychologist

Enc: Data Protection Guidance on the transportation of personal identifiable data

Appendix E

positive

Nottinghamshire Healthcare NHS
NHS Trust
Positive about integrated healthcare

Research Management and Development Department
Institute of Mental Health
University of Nottingham Innovation Park
Triumph Road
Nottingham
NG7 2TU

E-mail: emma.pearson@nottshc.nhs.uk
Direct Line: 0115 748 4320

Miss Laura Stone
Lincolnshire Partnership Foundation Trust
Faculty of Health, Life and Social Sciences
1st Floor, Bridge House
Brayford Pool
Lincoln
LN5 7TS

Our ref: AMH/25/02/13

Date of letter: 25th February 2013

Dear Miss Stone

Study Title: How clinical psychologists formulate from a cognitive behavioural perspective

PI/ CI: Laura Stone (Student)
LC: Dr Louise Braham
Supervisor: Dr Anna Tickle

Recruitment target: 10

Sites:
Adult Mental Health services - psychosis specific services
Rampton Hospital including Women's services

Summary: The study aims to find out how clinical psychologists develop and use cognitive behavioural formulations for people with psychosis, staff will be invited to take part in an interview that will last no longer than 60 minutes.

Thank you for submitting your project to the Nottinghamshire Healthcare NHS Trust's R&D Department. The project has now been given NHS permission for research on behalf of:

Dr Peter Miller: R & D Lead, on behalf of Nottinghamshire Healthcare NHS Trust

Although NHS permission for research has been given for this study it does not guarantee that independent contractors such as GPs, dentists, optometrists and community pharmacists will be able to take part in your study.

NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation. Permission is granted on the understanding that the

study is conducted in accordance with the Research Governance Framework, ICH GCP [ONLY if applicable], and NHS Trust policies and procedures available http://www.nottinghamshirehealthcare.nhs.uk/contact-us/freedom-of-information/policies-and-procedures/

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely

Shirley Mitchell
Head of Research Management and Governance

CC:

Sponsor: Mrs Judith Tompkins

Supervisor: Dr Anna Tickle

APPENDIX F

Derbyshire Healthcare NHS
NHS Foundation Trust

13 February 2013th

Research Unit
Kingsway House
Kingsway
Derby
DE22 3LZ

Tel: (01332) 623579
Email: Rubina.Reza@Derbyshcft.nhs.uk

Miss Laura Stone
Trainee Clinical Psychologist
Lincolnshire Partnership NHS Trust
DClinPsy Programme, Faculty of HLSS
University of Lincoln
1st Floor, Bridge House
Brayford Pool
Lincoln
LN6 7TS

Dear Miss Stone

I am writing to inform you that the Derbyshire Healthcare NHS Foundation Trust Clinical Research Committee has reviewed and granted NHS permission for the following study:

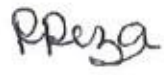
	Title:	How Clinical Psychologists formulate in CBT for psychosis
	REC ref:	Not Applicable
	Area:	Registered clinical psychologist employed by Derbyshire Healthcare NHS Foundation Trust using CBT with people experiencing psychosis
	Research Activity at site	• Letter of invitation and information to potential participants • Consent to participate • Completion of demographic information • Face to face hour long interview at a time and location convenient to the participant.
	Start date: 13/02/2013	**End date:** 30/10/2013
	Chief Investigator: Laura Stone, Trainee Clinical Psychologist, Lincolnshire Partnership Foundation Trust (Subject to issue of Derbyshire Healthcare NHS Foundation Trust letter of access)	

As part of our monitoring requirements, we will ask you for a progress report six months after the start of your study, and every six months as applicable. We will also ask you for a short summary of your research findings once the study is complete to assist in the dissemination process within the Trust.

You can now proceed with your study in accordance with the agreed protocol and the Research Governance Framework. Please notify us immediately of any adverse events or changes to the protocol

If you require any further information please do not hesitate to contact me.

Yours sincerely



Rubina Reza
Research and Clinical Audit Manager
On behalf of Dr John Sykes and the Clinical Research Committee

Documents reviewed:

- Research Proposal V.3 (31.10.12)
- Demographic Information Version 3 (31.10.12)
- Letter of invitation Version 3 (31/10/12)
- Participant Consent Form Version 3 (31.10.12)
- Participant Information Sheet Version 3 (31.10.12)

APPENDIX G

Participant ID number:.....

Lincolnshire Partnership NHS
NHS Foundation Trust

Version 3 (31.10.12)

Participant Consent Form for Research Study:

How clinical psychologists formulate from a cognitive behavioural perspective with people experiencing psychosis

Please read the following points and initial if you consent to participate in the study:

		Initials
1.	I confirm that I have read the participant information sheet (V.3 dated 31.10.12) and have had the opportunity to ask questions.	
2.	I understand that participation is voluntary that I am free to withdraw from the study for up to 72 hours following the interview; this time period excludes weekends between Friday 5pm and Monday 9am. After this time it will not be possible to withdraw data from the study.	
3.	I give permission for the interview to be audio recorded.	
4.	I understand that all information given by me or about me will be anonymised.	
5.	I understand that following the interview, I may be invited to take part in an optional second interview. If I do not wish to take part in the second interview, this will not affect the information provided in the first interview.	
6.	I agree to take part in the study.	

Name of participant..... Date.....

Signature.....

Witnessed by..... Date.....

Signature.....

Optional

Would you like to receive information regarding the findings of the study following its completion in October 2013? If so, the investigator will need to retain your contact details. Please tick 'yes' to receive this information or 'no' if you would rather not.

Yes please		No thank you	

APPENDIX H

Version 3 (31.10.12)

Demographic Information

The demographic information will not be used for any other than the present study without future consent. Additionally, it will be ensured that demographic information will be used to generally consider variations in data but this will not be written up in a way which could lead to the identification of individual participants.

Please describe the service you work for (e.g. community/inpatient/adult mental health/early intervention in psychosis)

.....

How long have you worked in this service for?

.....

What is the age range of the clients in the service?

.....

Approximately what proportion of the service users you work with are referred for problems relating to psychosis?

.....

Please estimate what proportion of the interventions you conduct are primarily within a cognitive behavioural framework?

.....

How long have you been qualified as a Clinical Psychologist?

.....

Have you undertaken further training or qualifications in CBT since qualifying as a Clinical Psychologist? If so please detail:

.....

.....

.....

Have you attended further training on formulation since qualifying? (Please detail)

.....

.....

APPENDIX I

Transcription System

The Jeffersonian transcription symbols (below) were referred to, although care was taken to preserve readability of extracts and to only use the level of detail necessary for the level of analysis. Therefore, only a selection of the symbols below was actually used. Furthermore, '**I**' was used to refer to the interviewer speaking and '**P**' to the participant speaking (both emphasised in 'bold'). The author used brackets within the text to show when the other speaker chipped in with speech e.g. (**I:** umm yeh).

Transcription Symbols (from Woofitt, 2001, p.62):

(.5)	The number in brackets indicates a time gap in tenths of a second.
(.)	A dot enclosed in a bracket indicates a pause in the talk of less than two tenths of a second.
.hh	A dot before an 'h' indicates an in-breath; the more 'h's, the longer the in-breath.
hh	An 'h' indicates an out-breath; the more 'h's, the longer the out-breath.
(( ))	A description enclosed in a double bracket indicates a non-verbal activity, for example ((banging sound)).
_	A dash indicates a sharp cut-off of the prior word or sound.
:	Colons indicate that the speaker has stretched the preceding sound or letter. The more colons the greater the extent of the stretching.
( )	Empty parentheses indicate the presence of an unclear fragment on the tape.
(guess)	The words within a single bracket indicate the transcriber's best guess at an unclear fragment.
.	A full stop indicates a stopping fall in tone. It does not necessarily indicate the end of a sentence.
,	A comma indicates a continuing intonation.
?	A question mark indicates a rising inflection. It does not necessarily indicate a question.
Under	Underlined fragments indicate speaker emphasis.
↓ ↑	Pointed arrows indicate a marked falling or rising intonational shift. They are placed immediately before the onset of the shift.

CAPITALS	With the exception of proper nouns, capital letters indicate a section of speech noticeably louder than that surrounding it.
°°	Degree signs are used to indicate that the talk they encompass is spoken noticeably quieter than the surrounding talk.
><	‘More than’ and ‘less than’ signs indicate that the talk they encompass was produced noticeably quicker than the surrounding talk.
=	The ‘equals’ sign indicates contiguous utterances.
[ ]	Square brackets between adjacent lines of concurrent speech indicate the onset and end of a spate of overlapping talk.
[[	A double left-hand bracket indicates that speakers start a turn simultaneously.

Appendix J

Interview Schedule 6

How

- What do you think the differences are when formulating from a CBT perspective for somebody experiencing psychosis than when formulating from a CBT perspective for other difficulties?
    - Is there a difference in the process you go through when developing a CBT formulation for somebody with psychosis rather than other difficulties?
    - Are there differences in what you're seeking during the assessment?
    - Differences in integration of information?
- What sources of information do you use to inform the CBT formulation for someone with psychosis?
    - Do you use a standardised interview structure? (if so, what?)
    - Do you offer client's a choice about completing standardised interviews?
- 'Is information to inform the formulation ever gathered from sources external to the client e.g. other staff/files?'
    - If so, 'Do you think collaboration is maintained in this process?'
    - 'How?'
- How do you make the decision about whether or not to formulate about all of a person's experiences or one specific aspect?
- Are there differences in the level that you decide to formulate at when working with someone with psychosis e.g. here and now or developmental?
- Is there a difference in how long it takes to develop a CBT formulation for someone with psychosis?
- Do you use a template CBT formulation for people with psychosis or do you develop idiosyncratic formulations?
- Are there any difference in how you communicate the formulation with somebody with psychosis in CBT?

- 'How do you go about 'making links' with the client?'
- Prompts: 'Are the links suggested to the client or does the client make the links themselves?'
- 'How do you manage when a client does not make these links?'
- 'How do you manage when the client disagrees with this links?'
- Do you think that the context of wider systems influences the CBT formulation process for people with psychosis?
    - Can you tell me more about that?
    - Influence on relationship?

Relationship

- How do you promote collaboration when developing a CBT formulation for someone with psychosis?
    - Do you think there are differences in how you would promote collaboration when working with someone with psychosis than when working with someone with other difficulties?
    - What do you do if you have a different understanding or formulation to the client?'
    - 'Are there ever situations when you hold a private formulation which differs to the shared formulation?'
- Do you think the therapeutic relationship plays a role in developing a CBT formulation for someone with psychosis?
    - Can you tell me more about that
- Do you think the CBT formulation influences the therapeutic relationship with somebody experiencing psychosis?
    - If so, how?

Challenges/Sensitivities

- Could you tell me about any factors that you're particularly sensitive to when developing CBT formulations specifically for individuals with psychosis?

Value (consider individuals and staff groups)

- What do you think are the benefits of developing a CBT formulation for someone with psychosis compared to other models?
- What might be the unhelpful aspects of developing a CBT formulation for someone with psychosis?
- What has your experience been of clients' responses to CBT formulations for psychosis; both positive and negatives.

Appendix K

UNIVERSITY OF LINCOLN

Data Protection Act 1998 Confidentiality Agreement for Transcribers

This Agreement is made as of 6/6/13 (Date), by and between the University of Lincoln, with principal offices at Brayford Pool Lincoln LN6 7TS (the University) and HELEN SMITH with principal offices at 21 SAXFIELD AVENUE, SYSTON, LEICS LE7 2LL (the Transcriber).

The Transcriber has been appointed by the University of Lincoln to transcribe audiotapes/audio files and documentation resulting from research undertaken by Laura Stone which will involve the disclosure to the Transcriber of personal data held by the University. Accordingly the Transcriber is required to deal with any such information in accordance with the terms of this Agreement and the Data Protection Act 1998.

The Transcriber undertakes to respect and preserve the confidentiality of personal data. Accordingly, for an indefinite period after the date of this Agreement the Contractor shall:

- maintain the personal data in strict confidence and shall not disclose any of the personal data to any third party;
- restrict access to employees, agents or sub-contractors who need such access for the purposes of the contract (and then only if the employee, agent or subcontractor is bound by conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request);
- ensure that its employees, agents or sub-contractors are aware of and comply with the Data Protection Act 1998; and
- not authorise any sub-contractor to have access to the personal data without obtaining the University's prior written consent to the appointment of such sub-contractor and entering into a written agreement with the subcontractor including conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request.

The Transcirber agrees to indemnify and keep indemnified and defend at its own expense the University against all costs, claims, damages or expenses incurred by the University or for which the University may become liable due to any failure by the Transcriber, its employees, agents or sub-contractors to comply with any of its obligations under this Agreement.

For the avoidance of doubt, the confidentiality imposed on the Transcriber by this Agreement shall continue in full force and effect after the expiry or termination of any contract to supply services.

The restrictions contained in this Agreement shall cease to apply to any information which may come into the public domain otherwise than through unauthorised disclosure by the Transcriber.

This Agreement shall be governed by and construed in accordance with the laws of England and the parties hereby submit to the exclusive jurisdiction of the English courts.

Signed for and on behalf of

Signed: HMSmith Name: HELEN SMITH

Title: MISS Date: 6/6/13.

Signed for and on behalf of the University of Lincoln

Signed: JM Tompkins Name: JUDITH TOMPKINS

Title: ADMIN OFFICER Date: 06.06.2013